COLORADO DERMATOLOGY SPECIALISTS

Greenwood Village:
7000 East Belleview Ave Suite 209
Greenwood Village, CO 80111
303-850-9715

Denver:
1960 N. Ogden St Suite 555
Denver, CO 80218
303-831-0400

HAIR LOSS QUESTIONNAIRE

Name: ____ **Date:** ____________________

Please share more about your hair loss condition by answering the following questions. There are some yes/no answers, and some questions require more detailed responses.

1. When did you FIRST notice that your hair was thinning? ______________________________
   - Is the hair coming out at the roots? YES ☐ NO ☐
   - Is the hair breaking off? YES ☐ NO ☐
   - Do you notice excess hair:
     - IN COMB ☐ ON SHOULDERS ☐ IN SINK ☐ ON THE PILLOW ☐
   - Do you have any totally bald spots? YES ☐ NO ☐
   - Have you ever counted the number of hairs lost daily? YES ☐ NO ☐
     - If yes, how many hairs lost daily: ______________________________

2. Have you recently noticed that your hair loss was worsening? YES ☐ NO ☐
   - If yes, when did you begin to notice it was worsening:

     ____
     ____
     ____
     ____
     ____

3. Please mark the box that best describes your family members' scalp hair (if you have more than one brother or sister, mark the box that best describes the brother or sister who has the least amount of hair):

	Has a lot of hair	Has some thinning	Has a small bald area	Has a large bald area
Father	☐	☐	☐	☐
Mother	☐	☐	☐	☐
Brother	☐	☐	☐	☐
Sister	☐	☐	☐	☐

4. Have you been pregnant at any time during the past year? YES ☐ NO ☐
   - If yes, when did the pregnancy end? ______________________________

5. Have you had a serious illness during the past year? YES ☐ NO ☐
   - If yes, approximately how long ago? ____
   - Have you had a fever of 103°-104° in the past year? YES☐ NO ☐

6. Have you been hospitalized during the past year? YES ☐ NO ☐
   - If yes, when did you leave the hospital? ____
   - Have you had major surgery in the past year? YES ☐ NO ☐
   - Have you had general anesthetic in the past year? YES ☐ NO ☐

7. Have you been under a sever amount of stress during the past 6 months? YES ☐ NO ☐

8. Have you started any special diets during the past year? YES ☐ NO ☐
   - Do you have anorexia nervosa? YES ☐ NO ☐

9. Are you a vegetarian? YES ☐ NO ☐

10. Please list the names of all the medications you are currently taking in the space below:
    Circle the medications you were taking when your hair began to fall out.

    ____
    ____
    ____
    ____
    ____

11. Please list any additional medications that you were taking when your hair began to fall out, but that you are **no longer taking:**

    ____
    ____
    ____
    ____
    ____

12. Please list any vitamins or natural products that you are taking:

    ____
    ____
    ____
    ____
    ____

   - Do you take Vitamin A? YES ☐ NO ☐
   - Do you take any vitamins with Vitamin A? YES ☐ NO ☐
     - If yes, how much total Vitamin A do you take? ______________________________

13. Do you get your menstrual period every month? YES ☐ NO ☐
   - If yes, how often does your period come? Every ________________ days
   - Have you needed to take birth control pills to make your periods regular? YES ☐ NO ☐

14. Have you experienced difficulty becoming pregnant? YES ☐ NO ☐

15. Do you have unwanted or excessive hair growth anywhere on your body? For example: increased hair on your abdomen, breasts or face? YES ☐ NO ☐
    - Do you have acne? YES ☐ NO ☐

16. How often do you wash/shampoo your hair? Every ________________ days
    - When did you last shampoo your hair? ____
    - Do you use a conditioner? YES ☐ NO ☐

17. How often do you chemically processed or straighten your hair?
    NEVER ☐ ONCE A WEEK ☐ EVERY 2-3 WKS ☐ EVERY 1-2 MONTHS ☐ A FEW TIMES A YEAR ☐
    - Do you color your hair? YES ☐ NO ☐
    - Do you bleach your hair? YES ☐ NO ☐
    - Do you use a blow dryer? YES ☐ NO ☐

18. Have your hormones ever been checked to evaluate your hair loss problem? YES ☐ NO ☐
    - If yes, when? ____
    - What was the result? ____

PLEASE FAX ALL RECENT (WITHIN THE LAST 6 MONTHS) LABS TO EITHER:
Denver (Midtown office) – fax # 303-831-0417
Greenwood Village (Belleview office) – fax # 303-850-0649

19. Have you ever been told by a doctor that you have a thyroid condition? YES ☐ NO ☐

20. Have you ever been treated with thyroid hormone? YES ☐ NO ☐

21. Have you ever been told by a doctor that you have a low iron level? YES ☐ NO ☐

22. Does your scalp itch a lot or sometimes burn or hurt? YES ☐ NO ☐
    - Do you have psoriasis? YES ☐ NO ☐
    - Do you have dandruff? YES ☐ NO ☐

23. Please list all prescription and non-prescription treatments that you've tried for your hair loss condition:

Treatment	When was it tried?	For how long?	Did it help?

24. What do you think is the cause of your hair loss?

____
____
____
____
____

DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS ON A REGULAR BASIS?

Medication	Response
Allopurinol (Zyloprim)	YES ☐ NO ☐
Phenytoin (Dilantin)	YES ☐ NO ☐
Aspirin	YES ☐ NO ☐
Carbameazepine (Tegretol)	YES ☐ NO ☐
Coumadin	YES ☐ NO ☐
Isotretinoin (Accutane)	YES ☐ NO ☐
Lithium	YES ☐ NO ☐
Birth Control Pills	YES ☐ NO ☐
Vitamin A	YES ☐ NO ☐
Multivitamins	YES ☐ NO ☐
Colchicine	YES ☐ NO ☐
Anticancer drugs	YES ☐ NO ☐
Amphetamines	YES ☐ NO ☐
Beta blockers (inderol, inderide, Lopressor)	YES ☐ NO ☐
Azulfadine	YES ☐ NO ☐
Gentamycin	YES ☐ NO ☐
Iodides	YES ☐ NO ☐
Levodopa	YES ☐ NO ☐
Penicilamine	YES ☐ NO ☐
Triparanol	YES ☐ NO ☐
Gold shots	YES ☐ NO ☐
Propythlouracil – PTU	YES ☐ NO ☐
Methimazole (Tapazole)	YES ☐ NO ☐
Atromid-S	YES ☐ NO ☐
Choloxin	YES ☐ NO ☐