Hair Loss Questionnaire -- Name_____Date_____

What type of treatment are you interested in?

Medical Treatment_____ Hair Transplantation _____
Platelet Rich Plasma_____ Laser Hair Growth_____ I don't know _____

How did you hear about Dr. Edwards? _____

Circle or fill in your answers:

My hair is: Thinning / Breaking / Shedding
Location: Scalp / Eyebrows / Eyelashes / Beard / Arms / Legs / Groin
This started: Weeks ago / Months ago / Years ago How many: _____
When is the last time your hair was **completely** normal in the area of concern: _____

I know what started my hair loss: Yes / No
If yes, please describe:
_____

Who in your family has thinning hair?: Men / Women / no one that I know of
Relationship(s) to you:_____
Does their thinning look like yours:_____
Have they been evaluated by a doctor:_____
*If yes, what is their diagnosis:*_____

I see hair in the: Sink / Shower / Pillow / Brush / Floor / Clothes / I don't see hair
The hair I see is: Broken / Full strand with small root / Full strand with large root

The number of hairs that fall out each day: More than 100 / Less than 100 / Unsure

My scalp itches: Yes / No
If yes, the itch is: Mild / Moderate / Severe
My scalp flakes: Yes / No
If yes, the flaking starts how many days after shampooing: _____
Does medicated shampoo control the flaking: _____
My scalp gets bumps: Yes / No
If yes the bumps look like: raised & flesh-colored / raised & red / pus bumps
My scalp gets sore: Yes / No
If yes, where: _____
My scalp turns red: Yes / No
If yes, what area of the scalp: _____

I shampoo every: Day / Week / 2 weeks / 4 weeks / Other (specify) _____

Hair dye use: Circle all that apply - permanent /semi-permanent /rinse/Henna/Other_____
I have been using dye for how long: _____
How often is it applied: _____
Last application: _____
*I've stopped dying my hair. (If yes, date of last application):*_____

Chemical use : Circle all that apply - Permanent Relaxer / Curly Perm / Texturizer

I've been using chemicals for how long : _____

Brand name if known:_____

Applied professionally: Yes / No

Applied how often and date of last applicaion: _____

I've stopped wearing chemicals. (If yes, when was last application):_____

Natural hairstyles (no heat): Circle all that apply - braids / locs / twists / afro

I've been wearing natural styles for how long: _____

I have artificial extensions in my hair : yes / no

Cared for professionally: Yes / No

Groomed or redone how often and date of last session : _____

Heat styling: pressing comb / flat iron / blow dryer / hood dryer /curling iron

I've been heat styling for how long: _____

How often? _____

I apply heat to my hair in between visits to the hair dresser: Yes / No

I wear a wig (specify) type – traditional / lace front / Other (specify)_____

At night I wear: Bonnet / rollers / Wrap / Nothing

Shampoo(s) I use: _____

Conditioner(s) I use: _____

Other products I use: _____

Hair moisturizer(s) I use: _____

I have been treated for this problem before: Yes / No

What doctor:_____ Year:_____

What treatments were done: (name of product and frequency)

Example: Betamethasone valerate 3x/week 6 months

Creams/ointments:_____How long:_____

Scalp Injections:_____How long:_____

Vitamins:_____How long:_____

Shampoo/Conditioner:_____How long:_____

Pills:_____How long:_____

Ultraviolet light:_____How long:_____

PRP:_____

Laser:_____

Transplant:_____

Biopsy done: Yes_____ No_____

If yes, when and by whom:_____

Result_____

Lab work done for hair loss: Yes_____ No_____

If yes, when_____

Photos done to track progress: Done by me ____ Done by my doctor_____ None _____

Other treatments received: _____