HAIR LOSS WORKSHEET

NAME: _____ DATE: _____

1. When did the hair loss start? _____
2. What areas on the scalp/body are you loosing hair? _____
3. Is the loss: ☐ Constant ☐ Worsening ☐ Improving ☐ Stable
4. Do you lose more than 100 hairs a day? ☐ Yes ☐ No
5. Is the hair coming out at the roots or breaking off? _____
6. Current hair care:

   Chemical treatments to the hair? ☐ Yes ☐ No Last treatment: _____ How often: _____

   Type of chemicals used: _____ Did it affect hair loss: _____

   How often do you shampoo you hair? _____ Which Shampoo: _____

   What conditioner is used? _____

   Please circle any current hair care:

   Blow dry hair Air dry hair Curling iron Wet set hair Hot combs Hot rollers

   Elastic hair items Head bands Hair weaves Hair pieces "Tight" styles (ex: pony tail, bun, braids)

7. Any previous history of hair loss? ☐ Yes ☐ No Was it ever investigated? _____
8. Is your scalp itchy, tender, painful, sore, or sensitive? _____
9. Do you pull or twist your hair? ☐ Yes ☐ No
10. Have you noticed any increase in hair growth on the face, chest, or legs? _____
11. Have you noticed any increase in acne or pimples? _____
12. General Health History- **Please circle all that apply**

Increased Fatigue	Weight loss	Brittle nails	Increased stress
Changes in menstrual period	Recent surgery	Recent severe illness	Lupus
Anemia (low iron)	Thyroid problems	Diabetes	Vitiligo (loss of color)
High Blood Pressure	Kidney problems	Liver problems	

13. Any recent pregnancies/ hormone/ birth control pills therapy before the hair loss? ☐ Yes ☐ No

    _____
14. Are your menses regular? ☐ Yes ☐ No Any history of hormone problems? ☐ Yes ☐ No
15. Is their any Family History of hair loss/ early balding? ☐ Yes ☐ No Who? _____
16. Any new medication that coincided with the hair loss? _____
17. Does anything make the hair loss: worse? _____

    better? _____

    Review by: _____