COLORADO DERMATOLOGY SPECIALISTS

Poplar:
3540 S. Poplar St, Suite 300
Suite 555
Denver, CO 80237
303-850-9715

Denver:
1960 N. Ogden St

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.

- 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:
      _____

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

- 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				

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

- 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

- 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

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

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

- Are you a vegetarian? YES NO

- 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.

  _____
  _____
  _____
  _____
  _____

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

  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

- 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?
      _____

- 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

- Have you experienced difficulty becoming pregnant? YES
  NO
- 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

- How often do you wash/shampoo your hair? Every _____ days
    - When did you last shampoo your hair?
      _____
    - Do you use a conditioner? YES
      NO

- 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

- 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
South Denver (Poplar office) – fax # 303-850-0649

- Have you ever been told by a doctor that you have a thyroid condition? YES
  NO
- Have you ever been treated with thyroid hormone? YES
  NO
- Have you ever been told by a doctor that you have a low iron level? YES

NO

- 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

- 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?

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

  _____
  _____
  _____
  _____
  _____
  _____

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

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**

Propythlouracil – PTU	**YES NO**
Methimazole (Tapazole)	**YES NO**
Atromid-S	**YES NO**
Choloxin	**YES NO**