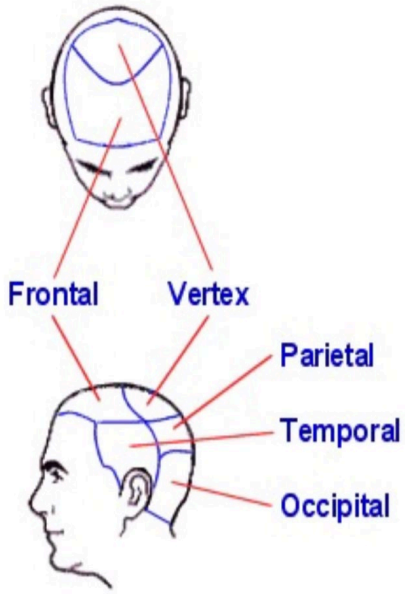
PALOMAR HEALTH MEDICAL GROUP®
Reimagining Healthcare™

Date:_____

DERMATOLOGY - HAIR LOSS IN WOMEN

Name:_____ DOB:_____
Race:_____ Height:_____ Weight:_____

1. When did you last have a normal head of hair? _____
2. Was onset of hair loss sudden or gradual? _____
3. Is your hair loss characterized by mostly shedding, mostly thinning, or both?
   _____
4. Is your hair coming out "by the roots" or is it breaking off? _____
   (Please shade in areas of location of hair loss on the map to the right.)
5. Is your hair thinning or is it shedding? _____
6. How often do you wash your hair? _____
7. What hair products do you use? _____
8. Do you use hot rollers, ponytails, braids, twists, locks, extensions, or weaves? _____How long? _____How often? _____
   If you have a weave, is it sewn in or glued? _____
9. Do you use hot combs, press and curl, curling irons or otherwise apply direct heat to your hair? _____
10. What type of hair chemicals do you use for your hair? _____
    _____
    Hair dye? _____ Name: _____
    Relaxer? _____ Name: _____
    Is it a relaxer that contains lye? _____ Do you have a permanent wave? _____
    Name: _____ How long? _____ How often? _____
11. Does your scalp itch? ☐ Little ☐ Moderate ☐ A lot
12. Do you get sores in your scalp? ☐ Yes ☐ No
13. Do you have seborrheic dermatitis? ☐ Yes ☐ No Psoriasis? ☐ Yes ☐ No
14. What medications are you allergic to? _____
15. What medications do you take? _____
    Do you use herbs or supplements? Yes ☐ No ☐
    Name: _____
16. If you are on birth control pills, which one? _____
    Have you recently started? _____ When? _____
    Or stopped your birth control pills? _____ When? _____
17. Are you on any other type of hormone treatment? _____
    Which one? _____ How long? _____
    Or stopped? _____ When? _____



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18. If applicable, are your menstrual periods regular? _____ Normal flow? _____
    If not, what is happening? _____ How long? _____
19. Have you gone through menopause? _____ Age? _____
20. Are you on any type of weight loss diet? _____
    Are you on a low protein diet? _____
    Are you a vegetarian (type)? _____
21. Any hair loss in men in your family? _____ Baldness? _____
    Any hair loss in women in your family? _____ How thin? _____
    Any family history of thyroid disease, anemia, or lupus? _____
22. What medical problems do you have? _____
23. Do you have?

a.	Severe headaches	☐ Yes	☐ No
b.	Double vision	☐ Yes	☐ No
c.	Excess facial hair	☐ Yes	☐ No
d.	Excess body hair	☐ Yes	☐ No
e.	Cystic Acne	☐ Yes	☐ No
f.	Discharge from breast	☐ Yes	☐ No
g.	Deepening of voice	☐ Yes	☐ No
h.	Enlargement of clitoris	☐ Yes	☐ No
i.	Polycystic ovary disease	☐ Yes	☐ No

24. Have you had in the last 3-12 months?

a.	High fever	☐ Yes	☐ No
b.	Childbirth	☐ Yes	☐ No
c.	Severe infection	☐ Yes	☐ No
d.	Flare of chronic illness	☐ Yes	☐ No
e.	Major surgery	☐ Yes	☐ No
f.	Over or under active thyroid	☐ Yes	☐ No
g.	Low protein diet	☐ Yes	☐ No
h.	Low iron in blood	☐ Yes	☐ No
i.	Severe psychological stress	☐ Yes	☐ No
j.	Start or stop birth control pills	☐ Yes	☐ No
k.	Start or stop hormone treatment	☐ Yes	☐ No
l.	Start or stop beta blocker medication	☐ Yes	☐ No

25. Do you see a rash in your scalp or on your face? _____
    If yes, please describe. _____
26. Treatments previously tried for hair loss? (Rogaine, Vitamins, Shampoos, etc.) _____
_____
_____

Questionnaire originally developed by Vera Y. Soong, M.D.