DERMWELLESLEY

PATIENT FORMS | UPDATED JANUARY 2025

INITIAL CONSULT FOR HAIR LOSS QUESTIONNAIRE

NAME: _____ **DOB:** _____

History of Hair Loss and Scalp Health

What type of hair loss are you experiencing? (Please check all that apply)

- ☐ Bald Patches
- ☐ Excessive Shedding
- ☐ General Loss/Overall Thinning

Areas affected by hair loss:

- ☐ Scalp
- ☐ Other Areas: _____

Associated symptoms on the scalp, such as itching, burning, pain, or flaking?

Itching?

☐ No ☐ Mild ☐ Moderate ☐ Severe

Burning?

☐ No ☐ Mild ☐ Moderate ☐ Severe

Pain?

☐ No ☐ Mild ☐ Moderate ☐ Severe

Flaking?

☐ No ☐ Mild ☐ Moderate ☐ Severe

How long (approximately) have you been experiencing hair loss? _____

Was onset or hair loss:	☐ Sudden	☐ Gradual	
Since onset, has it gotten:	☐ Better	☐ Worse	☐ Stayed the Same
Any history of hair loss in men in your family?	☐ No	☐ Yes	☐ If YES, who: _____
Any history of hair loss in women in your family?	☐ No	☐ Yes	☐ If YES, who: _____

What treatments has the patient tried, and for how long have you used them?

_____

_____

Hair Care and Styling

How often do you wash your hair? _____

How often do you use heat styling (curl, straighten, blow dry, etc.) _____

How often do you color your hair? _____

How often do you perm or chemically relax your hair? _____

Do you regularly have any of these hairstyles that increase tension or tugging on hair:

- ☐ Ponytails
- ☐ Braids
- ☐ Twists
- ☐ Dreadlocks
- ☐ Weaves
- ☐ Extensions
- ☐ Headbands

How often do you use any of the above? _____

Health History

Do you adhere to a special diet, such as vegetarian or vegan (please specify)? _____

If YES, for how long have you followed this diet? _____

Have you had any blood work done recently? _____

Have you ever had a scalp biopsy? _____

Do you have:

- ☐ Psoriasis
- ☐ Anemia
- ☐ Hyper or Hypothyroid
- ☐ Cystic Acne
- ☐ Enlargement of Clitoris
- ☐ Any autoimmune disease (please list:): _____ _____
- ☐ Excess body or facial hair
- ☐ Lichen Planus
- ☐ Syphilis
- ☐ Deepening of voice
- ☐ Polycystic ovary disease

In the last 3-12 months, have you experienced any of the following:

- ☐ High fever
- ☐ Childbirth
- ☐ Severe infection
- ☐ Flare of chronic illness
- ☐ Major surgery
- ☐ Start or stop beta blocker medication
- ☐ Start or stop hormone treatmet Start
- ☐ or stop birth control pills Weight loss
- ☐ Weight gain
- ☐

Please explain if you checked any of the above: _____

_____

Have you experienced a major emotional or physical event? _____

_____

Are there any additional comments about your hair that you want to share? _____

_____

Female Patients

If you are premenopausal, do you have a regular 28-day cycle? _____

Do you use any form of hormone-based contraception? _____

If you are post-menopausal, at what age did you go through menopause? _____

Do you use hormone replacement therapy? _____