

Hair Loss Intake Form

Name: _____ DOB: ____/____/____

History of Hair Loss and Scalp Health

When did your hair loss begin (approximately)? _____

Where are you experiencing hair loss? Scalp Other areas _____

Is your hair loss: General Patches or Both

Was onset of hair loss: Sudden or Gradual

Since onset, has it gotten: Better Worse or Stayed the same

Is your hair: Thinning Shedding or Both

Does your scalp itch? No Mild Moderate Severe

Is your scalp flaking? YES NO

Hair Care and Styling

How often do you wash your hair? _____

What hair products do you use? _____

Do you use:

Hot rollers

Relaxer/Keratin?

Use hair dye

Rollers

Curling iron

Straightening iron

Other hair treatment chemicals: _____

How often do you use any of the above? _____

Do you regularly have any of the following hair styles:

Ponytails

Weaves

Braids

Extensions

Twists

Headbands

Dreadlocks

How often do you use any of the above? _____

Where do you see hair? Home Shower Other: _____

How many hairs do you estimate you are losing at a time?

About a 100

More than 100

I don't know, but the hair is in clumps

Where have you noticed hair loss (CIRCLE ALL THAT APPLY)?

Top/front of scalp

Sides of scalp

Back of scalp

Armpits

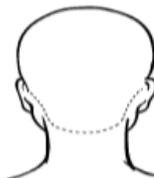
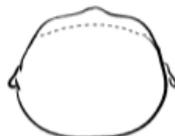
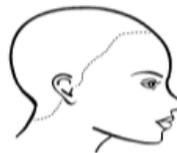
Groin

Eyebrows

Legs

Eyelashes

Draw on the diagram where the hair loss is the most



Health History:

Do you have:

- | | |
|---|---|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Excess facial hair |
| <input type="checkbox"/> Seborrheic dermatitis | <input type="checkbox"/> Excess body hair |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Discharge from breast |
| <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Deepening of voice |
| <input type="checkbox"/> Enlargement of clitoris | <input type="checkbox"/> Polycystic ovary disease |
| <input type="checkbox"/> Do you have any divots/impressions/dots or ridges on your nails? | |
| <input type="checkbox"/> History of Radiation | <input type="checkbox"/> History of chemotherapy |
| <input type="checkbox"/> History of thyroid disease | <input type="checkbox"/> History of crash dieting or rapid weight loss, |
| <input type="checkbox"/> History of Low levels of iron, zinc, and vitamin D | |
| <input type="checkbox"/> low molecular weight heparin (and less commonly warfarin) | |
| <input type="checkbox"/> History of autoimmune disease (please list): _____ | |

In the last 3-12 months, have you experienced?

- | | |
|---|--|
| <input type="checkbox"/> High fever | <input type="checkbox"/> Start or stop beta blocker medication |
| <input type="checkbox"/> Childbirth | <input type="checkbox"/> Start or stop hormone treatment |
| <input type="checkbox"/> Severe infection | <input type="checkbox"/> Start or stop birth control pills |
| <input type="checkbox"/> Flare of chronic illness | <input type="checkbox"/> Severe psychological stress |
| <input type="checkbox"/> Major surgery | <input type="checkbox"/> prolonged illness or hospitalization |

Any history of low libido, ejaculation, and orgasm problems

Any history of depression? YES NO

Any history of sexual dysfunction? YES NO

Have you recently dramatically changed your diet? YES NO

Are you a vegetarian? YES NO

Do you see a rash in your scalp or on your face? YES NO

If yes, please describe: _____

Are you on any type of hormone treatment? YES NO

If YES, what type and for approximately how long? _____

Explain your history of hormone use: _____

Female Patients Only

Do you have hair growth on your? Chin/thick sideburns Chest/nipples
 Area below your belly button

Are you using a hormonal birth control? YES NO

If YES, what type and for approximately how long? _____

Or if you have recently stopped taking it, when did you stop? _____

If applicable, are your menstrual periods (check all that apply):

- Regular Irregular Light Moderate Heavy

Have you gone through menopause? YES NO If YES, what age? _____

Family History

Which family members have had hair problems (CIRCLE ALL THAT APPLY)

- Mom / Dad Siblings Children Grandparents

PREVIOUS TREATMENTS

List all other doctors, their specialty, and when treated for this problem? _____

What lab tests were performed? _____

Was a biopsy performed? YES NO

Use of Minoxidil (Rogaine)? Past Present How long? _____

Strength (2 or 5%) Did it work? YES NO

Did it cause more hair to fall out in the beginning? YES OR NO

Any side effects?

Biotin YES OR NO dose:

Spirolactone/Aldactone Dose: _____ How long? _____

Shampoo/conditioner system like Viviscal YES OR NO

Finasteride(Propecia) Dose? _____ How long? _____ -

Dutasteride Dose? _____ How long? _____ -

LED light devices / helmets? Name _____ How long? _____

Ketoconazole shampoo How long? _____ -

Steroid injections / Prednisone Use? Dose? _____ How long? _____ -

Antibiotics (doxycycline, clindamycin, benzoyl peroxide) YES OR NO list:

Iron supplements (dose) YES OR NO dose:

Other vitamins (list:) _____

Any side effects from treatments(i.e scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc)

Has any treatment helped more than others (explain)?

SOCIAL IMPACT

What is your occupation? _____

How severely has it affected your life? _____

Are you fearful of becoming bald? _____

MEDICATIONS ASSOCIATED WITH HAIR LOSS Circle any medications taken since you noticed hair loss

Telogen Effluvium

Psychotropic Agents	Lithium	Sodium Valproate	SSRIs (Fluoxetine)
Anticoagulants	LMW heparins (enoxaparin, dalteparin)	Warfarin	
Cardiovascular Agents	Beta Blockers (Metoprolol, Propranolol)	ACE Inhibitors (Captopril)	
Cessation of Oral Contraceptives			
Retinoids	Acetretin	Isotretinoin	Vitamin A supplements
Antimicrobials	Isoniazid	Antiretrovirals (Indinavir)	

Anagen Effluvium

Chemotherapeutic Agents
Radiation

Androgenetic Alopecia (AGA)

Androgenic Agents: *May accentuate AGA*
Testosterone Anabolic Steroids DHEA Levonorgestrel (Mirena,certain contraceptives)

Please bring any lab testing and biopsy results from the other doctors and their last office visit note to your visit.

What goals or expectations do you have for treatment? _____

- ❖ Your physician will review your history and perform an exam. If interested in having PRP and / or regenerative stem cells, then additional tests may be performed. This include Iron, Zinc, and Vitamin D, TSH, Free T3, 8am Cortisol, Testosterone, liver profile, Estrogen, Progesterone.
- ❖ Once your physician has reviewed your history, medical records, lab, and any other studies, then he will perform an assessment whether you are a good candidate. He will then review consent(s), benefits, and risks with you.

Patient Signature: _____ Date: ____/____/_____