NOVA
DERMATOLOGY

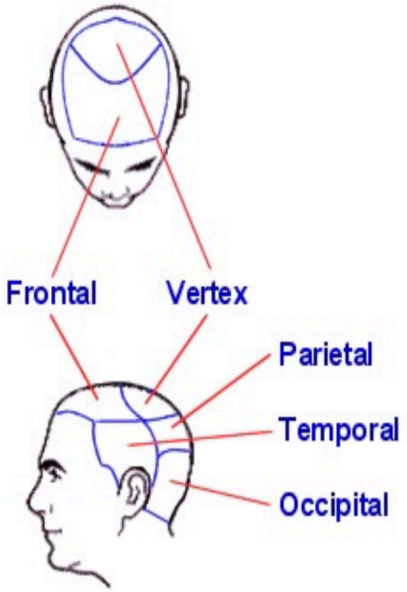
Sandra Kopp, M.D.

Date:_____

HAIR LOSS

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 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.)
4. Is your hair thinning or is it shedding? _____
5. How often do you wash your hair? _____
6. What hair products do you use? _____
7. 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? _____
8. Do you use hot combs, press and curl, curling irons, flat irons or otherwise apply direct heat to your hair? _____
9. How often do you blow dry 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 (Circle)
12. Do you get sores in your scalp? Yes No
13. Do you have dandruff? Yes No Psoriasis? Yes No
14. What medications are you allergic to? _____
15. What medications do you take ? _____
    Do you use OTC 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? _____
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? _____
    Any dietary restrictions? _____
    Are you a vegetarian (type)? _____
21. Any hair loss in men in your family? _____
    Any hair loss in women in your family? _____
    Any family history of thyroid disease, anemia, or lupus? _____
22. What medical problems do you have? _____
    _____

23. Have you had a hysterectomy? ▫ Yes ▫ No
24. 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
25. 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 stressor ▫ Yes ▫ No
    j. Death of loved one ▫ Yes ▫ No
    k. Start or stop birth control pills ▫ Yes ▫ No
    l. Start or stop hormone treatment ▫ Yes ▫ No
    m. Start or stop beta blocker medication ▫ Yes ▫ No
26. Do you see a rash in your scalp or on your face? _____
    If yes, please describe. _____
27. Treatments previously tried? (Rogaine, Vitamins, Shampoos, etc.) _____
    _____
    _____
28. Any biopsy or blood work done for hair loss? _____