

BAY AREA DERMATOLOGY QUESTIONNAIRE
EVALUATION OF HAIR LOSS

Date _____

1. Is there any family history of hair loss? _____
2. Are there any bald men in your family? Yes No -Who? _____
3. Are there any women in the family with thin hair? Yes No - If so, Who? _____
4. Have you had any surgery in the last year? Yes No - If so, what _____ when _____
5. Have you been in the hospital in the last year? Yes No – If so, when? _____
6. Have you had any severe infections or high fever in the last year? (for example, cold, flu, urinary tract infection, bronchitis, etc?) Yes No – If yes: what _____
7. Have you had a baby in the last year? Yes No _____
8. Are you on any special diet? Yes No -Specify _____
9. Do you take any medications for:

| | | |
|---------------------|--|-------|
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Thyroid problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Gout | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
10. Do you take any of the following medications? If yes, list?

| | | |
|----------------------|--|-------|
| Blood Thinners | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Hormones | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Birth Control Pills | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Anti-Depressants | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Anticonvulsants | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Mouth Washes | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Vitamins, Which ones | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Anti-Inflammatories | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
11. Do you take any of these medicines? Yes No ... Iodine, Propylthiouracil, Premarin, Gold, Cholestyramine, Colchicine, Captopril, Enalapril, Fluconazole, Nicotinic Acid, Allopurinol, Interferon, Clofibrate, Lithium, L-Dopa, Furadantin, Pepto-Bismol, Vitamin A., Propanolol, Probenecid
If Yes, List which ones? _____

12. List any other pertinent information you feel might be important to the doctor:

