Hair loss Questionnaire (Men)

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Name__________________________**Age**_____________

Shedding: Excessive number of hair falling daily.
Thinning: Having less hair to cover scalp, without excessive hair lost every day.
Balding : Excessive loss of hair in one are leaving visible skin.

When did first noticed the hair loss or thinning?

- Less than a month.
- More than a month.
- More than month but less than year.
- More than year.
- Others.

Does it affect the scalp alone, or does it occur elsewhere on the body?

- Only scalp.
- On the face.
- Other parts of the body also.

Are the lost hair are?

- In patches.
- Diffusely (evenly all over the scalp)

Have you been noticing lots of hair in the shower, tub, hair brush or on your pillow?

- Yes
- No
- Always

Have you been noticing your hair are slowly thinning out over the time ?

- Yes
- No

Any body in your family has had the similar pattern of hair loss?

- Yes
- No
- Don’t know

Any recent weight changes?

- Did not gain or loose any pound in last 6 months.
- Did gain more than 10 lbs in last 6 moths.
- Did loose more than 10 lb in last 6 moths.

Are you having anorexia, nausea, vomiting or upset stomach?

- Yes
- No

Have you ever had jaundice, edema, hyper pigmentation, pallor, or duskiness?

- Yes
- No
- Don’t know

Are you having excessive stress?

- Yes still have it.
- Used to have it.
- Sometimes.
- Never

Have you been noticing white spots or pitting in your nails?

- Yes
- No

Have you been ever had exposure to insecticides or pesticides?

- Yes
- No
- Don’t know

Do you think you have been exposed to EMF’*s more than usual? (*Electro magnetic frequencies)

- Yes
- No
- Don’t know

Have you ever taken medications for over or under active thyroid?

- Yes
- No

Have you noticed decreased/increased libido or loosing interest in sex?

- Yes
- No

Hair care.

Do you use a hot blow dryer or electric curlers?

- Yes once in a while
- Daily
- Never

Do you periodically dye, bleach, or perm your hair?

- Yes
- No
- Always
- Sometimes

Are you frequent to swimming pool or beach very often?

- Yes
- No

Do you have the habit of pulling the hair or twirling it around the fingers when nervous?

- Yes
- No

What kind of shampoo, conditioner or cleansers you use please explain?

Dietary and Life style:

You are: Please pick the right choice.

- Vegan.
- Vegetarian.
- Non-Vegetarian.
- Eat meat occasionally.
- Others.

How many serving of fruit and vegetables you eat daily?

- Less than one serving or none daily
- One to three servings daily.
- More than three but less than six.
- More than six servings daily.

Do you do any walking or exercise?

- Walk ____minutes ___times a week.
- Exercise___minutes___times a week.

How many hours do you sleep?

- 5-6 hours each nigh
- 4-5 hours each night.
- 7-8 hour each night.
- More than 8 hours.

Any other information you want to share regarding your health?

(Please fill this questionnaire carefully and fax it. You can also bring it with on your first appointment)