Date: _____

HAIR TRANSPLANT AND RESTORATION CENTER

GENERAL HAIR LOSS HISTORY

Please complete the following form, save it, and email it to us at info@htandrc.com
(If there are any changes in the future, please let us know)

Patient Name: _____ Date of Birth: _____

1) What area or areas of hair loss are you experiencing?

2) What is the main problem? (itching, scaling, thinning areas, etc)

3) Have you previously been affected by any type of hair loss? If so explain.

4) When did this particular hair loss begin? _____

5) Does anyone in your family have hair loss? What is the amount, age of onset and relationship to you? Be as specific as possible.

6) Has the hair loss increased, decreased or stayed the same? _____

7) How many hairs are you losing daily? _____

8) Do you feel that you have been shedding excessive numbers of hair?

9) Do you feel that your scalp hair is slowly thinning out over the top without losing excessive numbers of hair daily?

10) Are you losing hair from the entire scalp, or is it more noticeable on the top?

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11) Are any of the hairs short and without color (pigment)? _____

12) Where do you mainly lose them? (tub, sink, brush, or comb, etc)

13) Do your hairs come out at the root or break off? _____

14) Do you pull and or twist your hair? _____

15) Has your hairline or temporal area receded?

16) Have your noticed the middle part in your hair widening?

17) Does the hair seem dull, brittle, or uncombable? _____

18) Has the appearance changed; is it straight vs curly?

19) Has anyone other than you noticed or mentioned your hair loss?

20) Have there been any changes in your nails, skin, teeth or mouth?

21) Do you sweat normally? _____

22) Do you consider your hair loss:

23) Do you think about your hair loss:

24) Are you preoccupied with your hair loss daily such that it:

25) Do you feel your hair loss makes you especially unattractive? _____

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26) Do you think about hair loss a lot and wish you could think about it less?

27) Have you ever pulled your hair such that it left bald spots?

28) How have you usually worn your hair throughout your life?

HAIR CARE QUESTIONAIRE

1) How often do you shampoo? List all products used on your hair.

2) Did you shampoo today? _____

3) Have you changed your hairstyle recently or within the last 6 months?

4) Do you wear a fall or use hair extensions? _____

5) Do you braid, plait, tease or wear a bun or ponytail? How often?

6) Do you use relaxers, pomades, or straighteners? _____

7) Do you perm, color, dye, or bleach your hair? How often and with what products?

8) Do you use hot or sponge rollers, hot combs? How often?

9) Do you use rubber bands, hairpins or other ornaments? _____

10) Do you blow-dry you hair? _____

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