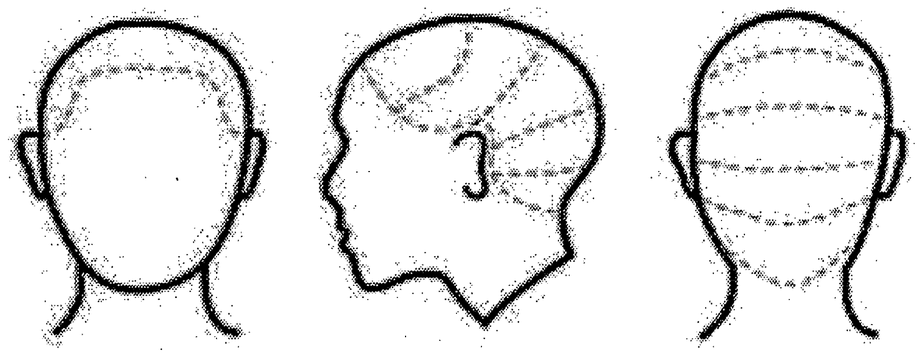
PENNSYLVANIA CENTRE FOR
DERMATOLOGY

PATIENT STICKER

1. WHERE IS YOUR HAIR LOSS?



(Pease check ✓ options that apply)

- ☐ SCALP (*please indicate location on the diagram to the right)
  - ☐ DIFFUSE THROUGHOUT? —OR—
  - ☐ DISCRETE PATCHES OF HAIR LOSS?
- ☐ EYEBROWS
- ☐ EYELASHES
- ☐ OTHER BODY AREA: _____

_____

_____

2. APPROXIMATE DATE OF ONSET: _____

3. HAVE ANY OF THE FOLLOWING EVENTS OCCURRED IN THE MONTHS PRIOR TO HAIR LOSS? (PLEASE CHECK ✓ ALL OPTOINS THAT APPLY)

- ☐ DELIVERY OF A BABY
- ☐ SURGERY/GENERAL ANESTHESIA
- ☐ MAJOR LIFE-ALTERING STRESS? (I.E. LOSS OF LOVED ONE, LOSS OF JOB, DIVORCE, ETC.)
- ☐ SIGNIFICANT OR SUDDEN WEIGHT LOSS/GAIN?
- ☐ VIRAL ILLNESS/FEVER
- ☐ OTHER (PLEASE PROVIDE DETAILS BELOW)

_____

4. HAVE YOU STARTED ANY NEW MEDICATIONS WITHIN 6 MONTHS OF THE START OF YOUR LOSS? IF SO, PLEASE LIST BELOW.

_____

_____

_____

5. DO YOU FOLLOW A SPECIAL DIET? (I.E. VEGETARIAN/VEGAN/ETC)

YES/ NO (PLESE CIRCLE)

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6. DO YOU HAVE ANY SYMPTOMS ASSOCIATED WITH THE HAIR LOSS?

(PLEASE CHECK ✓ ALL OPTOINS THAT APPLY)

- ☐ PAIN
- ☐ REDNESS
- ☐ SCALING
- ☐ ITCHING
- ☐ NO SYMPTOMS
- ☐ OTHER: _____

7. WHAT TREATMENTS HAVE YOU TRIED?

MEDICATION	DATES
MINOXIDIL (ROGAINE®)	
FINASTERIDE (PROPECIA)	
BIOTIN OR OTHER HAIR VITAMIN	
SPIRONOLACTONE	

8. HAVE YOU BEEN SEEN BY ANOTHER PROVIDER FOR YOUR HAIR LOSS?

IF SO....

DIAGNOSIS: _____

TREATMENT: _____

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9. BLOODWORK

DATE LAST DRAWN	
RESULTS (IF YOU KNOW THEM)	
WHERE DID YOU HAVE YOUR BLOOD DRAWN? (QUEST, LAB CORP, ETC)	
CAN YOU PROVIDE A COPY?	YES / NO (PLEASE CIRCLE)

10. DO YOU HAVE A HISTORY OF: (please check ✓ options that apply)

- ☐ IRON DEFICIENCY ANEMIA
- ☐ THYROID DISORDER
- ☐ LUPUS
- ☐ NAIL ABNORMALITIES (Ridges/Grooves/Pitting/etc.)
- ☐ FAMILY HISTORY OF HAIR LOSS
  (Please indicate family member below and age of onset)

11. FEMALES ONLY: ARE YOU EXPERIENCING THE FOLLOWING?

(please check ✓ options that apply)

- ☐ IRREGULAR MENSTRUAL CYCLE
- ☐ HAIR ALONG THE JAWLINE/CHIN
- ☐ CHEST HAIR
- ☐ DEEPENING OF VOICE
- ☐ ACNE ALONG THE JAWLINE/CHIN

12. HAIR PRACTICES

HOW OFTEN DO YOU WASH YOUR HAIR?	
WHEN WAS THE LAST TIME YOU WASHED YOUR HAIR?	
WHAT HAIR PRODCUTS DO YOU USE DAILY?	

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13. HAVE YOU EVER DONE THE FOLLOWING?

- ☐ HEAT/CHEMICAL PERMS
- ☐ CHEMICAL STRAIGHTENING
- ☐ HOT IRONS OR BLOW-DRYING
- ☐ BRAIDING
- ☐ HAIR COLOR

14. IS THERE ANYTHING ELSE THAT YOU WANT US TO KNOW? (Please indicate below)

REVIEWED BY: _____

DATE: _____