BMC HAIR CLINIC - PATIENT QUESTIONNAIRE – SHAPIRO CENTER

PLACE STICKER HERE Name:

1. Do you have hair thinning? Y / N Falling out? Y / N
   Bald spots? Y / N Breakage? Y / N

2. How long has this been going on?

3. Is your scalp itchy? Y / N Painful? Y / N Burning? Y / N
   Do you have other symptoms? Y / N IF YES, PLEASE EXPLAIN:

4. How often do you shampoo your hair? Please list which hair products you use:

5. Have you ever used hair:

coloring?	Y / N	Do you use them regularly?	Y / N	How frequently?	For how long?
relaxers/perms?	Y / N	Do you use them regularly?	Y / N	How frequently?	For how long?
extensions?	Y / N	Do you use them regularly?	Y / N	How frequently?	For how long?
weaves?	Y / N	Do you use them regularly?	Y / N	How frequently?	For how long?
hot combs/hot dryer?	Y / N	Do you use them regularly?	Y / N	How frequently?	For how long?

Do you use a salon regularly? Y / N If yes, name, location and products used_____

6. Please circle which, if any, you have had:

acne	anemia	cancer	excess facial hair
irregular periods	lupus	ringworm	thyroid disease

7. Please list all your **current medications** including birth control pills and vitamins:

8. Do you follow a special diet, have an eating disorder or gastrointestinal illness? Y / N DETAILS:

9. Do you have any **medication allergies?** Y / N DETAILS:

10. Have you recently:
    - Been pregnant, hospitalized or had surgery? Y / N DETAILS:
    - Been diagnosed with a major illness? Y / N DETAILS:
    - Had a major emotional event (death in the family, divorce, etc?) Y / N DETAILS:

11. Does anyone in your family (parents, siblings, aunts/uncles, grandparents) have hair loss, including mild or early baldness? Y / N
    DETAILS: