DIABETES ASSOCIATES MEDICAL GROUP

PATIENT NAME: DATE OF BIRTH:

HAIR DISORDER QUESTIONNAIRE (CIRCLE FOR YES OR GIVE ANSWER)

When did the hair loss start (duration?)
Loss of hair on (Please circle) scalp, eye brow, eye lashes, axillae, pubic area).
Excess hair on (Please circle) mustache, scalp, eye brow, eye lashes, axillae, pubic area).
Loss of hair has been of (Please circle) slow onset, slowly progressive, abrupt onset, rapid progression,
Was hair loss first noticed after (Please circle) a traumatic event, after a recent pregnancy, after using the new hair shampoo or product?
Do you have any psychiatric problems or stress?
Do you compulsively pull your hair?
Do you perm your hair or vigorously brush the hair?
Do you have (Please circle) acne, irregular menses, infertility, enlargement of the clitoris, deepening of the voice, increased libido, loss of female body contour, skin pigmentation, hot flashes, breast discharge?
Do you have a history of (Please circle) thyroid disease, calcium disorder such as low calcium, polycystic ovarian syndrome, ovarian or adrenal disease, fungal skin infection, Cushing's syndrome, diabetes mellitus, insulin resistance syndrome, Lupus, dermatomyositis, lymphoma?
Do you take or use (Please circle) Hydrocortisone, Anabolic steroids, Testosterone, Danazole, Minoxidil, Rogaine, thyroid medications.
Does your spouse use testosterone gel on the skin?
Have you had radiation therapy?
Have you had chemotherapy?
Please see the section on the website for medication list and fill out the form.