

SKIN SERIOUSLY.

Hair Loss Intake Questionnaire

How long have you had hair loss?

Where have you noticed the hair loss?

Have you noticed increased shedding of hair? **YES NO**

Have you had gradual hair loss? **YES NO**

Have you had sudden hair loss? **YES NO**

Do you have a rash on your scalp? **YES NO**

Do you have itching or pain on your scalp? **YES NO**

Do you have a longstanding medical illness? **YES NO**

Do you have bald spots? **YES NO**

Do any family members have hair loss and if so which family member?

Do you or any family members have thyroid disease? **YES NO**

Have you lost weight or been on a diet in the last 6 months? **YES NO**

Do you use chemical perms, relaxers, or dye on your hair? **YES NO**

Have you had high fever, surgery, change in medications, infection, or pregnancy in the last 6 months? If so please describe:

Any other information pertaining to your hair loss that you feel would be helpful for the Doctor to know:

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Hours:
Monday:
12:00 pm - 7:00 pm
Tuesday - Friday:
8:00 am - 5:00 pm