DERMATOLOGY CENTER
1452 Waukegan Road Glenview IL 60025 (847) 832-1185

NAME: _____ **DOB:** _____
(Last) (First) (MI)

NAME OF PHYSICIAN THAT REFERRED YOU? : _____

WHERE IS YOUR HAIR LOSS?

- □ Eyebrows
- □ Eyelashes
- □ Scalp
- □ Other: _____

HOW DID THE HAIR LOSS OCCUR?

- □ Gradual (slow, advancing step by step)
- □ Sudden (happened quickly w/no warning)

HOW SEVERE IS YOUR HAIR LOSS?

- □ Mild (25% or less of hair lost)
- □ Moderate (25%-50% of hair lost)
- □ Severe (75% or more of hair lost)

HOW LONG HAVE YOU HAD HAIR LOSS?

(Please specify in numbers)

□ Years: ____ □ Months: ____ □ Weeks: ___

DOES YOUR SCALP HAVE ANY OF THE FOLLOWING SYMPTOMS?

- □ Asymptomatic (no symptoms)
- □ Bumps
- □ Burning
- □ Drainage
- □ Flaking
- □ Itching
- □ Redness
- □ Scaling
- □ Tenderness
- □ Other: _____

PLEASE CHECK (√) ALL THAT APPLY:

- □ A recent hospitalization
- □ A recent illness
- □ A recent surgery
- □ A systemic disease
- □ NONE of the above
- □ Unintentional weight change
- □ Anemia
- □ Hyperthyroidism
- □ Hypothyroidism

HAVE YOU HAD ANY PREVIOUS BLOODWORK/LABS DONE (Ferritin, TSH, etc.)?

□ Yes – If so, when? _____
□ No

WHAT ARE YOU CURRENTLY TAKING OR USING TO TREAT HAIR LOSS?

□ Biotin
□ Clobetasol
□ Minoxidil 2 % (Rogaine)
□ Minoxidil 5 % (Rogaine)
□ Propecia/Finasteride
□ Other: _____
□ NONE/No treatment

WHO IN YOUR FAMILY HAS OR HAD HAIR LOSS/HAIR THINNING/BALDING?

□ Brother
□ Sister
□ Daughter
□ Son
□ Father
□ Mother
□ Cousin
□ Aunt
□ Uncle
□ Grandfather – Paternal
□ Grandfather – Maternal
□ Grandmother – Paternal
□ Grandmother – Maternal
□ NONE of the above

ARE YOU INTERESTED IN PLATELET-RICH PLASMA TREATMENT (PRP)?

□ Yes
□ No

ADDITIONAL HISTORY: *PLEASE LIST BELOW*

_____

_____

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