DERMATOLOGY INFORMATION SHEET
HAIR LOSS

Patient Name ______________________________ **Today's Date** ____________

Family Physician ______________________________ **Referred By** ____________

Approximate Duration of Hair Loss: ______________________________

Has anyone else in your family had a similar problem? **Yes** **No**

Are you allergic to any medications? **Yes** **No** If so, which ones? ______________________________

What medications are you taking now? ______________________________

Have you taken aspirin, aspirin-containing medications, or blood thinners in the last 10 days? **Yes** **No**

If yes, which ones? ______________________________

Do you have a history of a bleeding problem? **Yes** **No** If yes, what type?.______________________________

Is there a family history of skin cancer? **Yes** **No** If yes, what relatives and, if known, what type of skin cancer? ____________

Do you have any history of moles that have gotten larger, darker, that get irritated by the sun, or have bled? **Yes** **No**

Do you have any specific questions you wish to have answered? ______________________________

Do you have a history of any of the following? Answer by Selecting Yes or No

Yes	**No**	Diabetes	**Yes**	**No**	Heart Disease
Yes	**No**	High Blood Pressure	**Yes**	**No**	Heart Murmur
Yes	**No**	Lung Disease	**Yes**	**No**	Heart Valve Replacement
Yes	**No**	Cancer	**Yes**	**No**	Pacemaker
Yes	**No**	Collagen Vascular Disease	**Yes**	**No**	Heart Surgery
Yes	**No**	Rheumatoid Arthritis	**Yes**	**No**	Liver Disease
Yes	**No**	Lupus	**Yes**	**No**	Joint Replacement
Yes	**No**	Tobacco Use	**Yes**	**No**	Alcohol Use
Yes	**No**	Drug/Narcotic Use	**Yes**	**No**	Excessive Alcohol Habit

If yes to any except smoking and moderate alchohol, please give brief explanation:

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Do you have a history of Hepatitis or HIV infection? **Yes** **No**

Do you have a history of exposure to tuberculosis or a positive TB test? **Yes** **No**

Please list any surgeries you have had in the past five years ______________________________

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Please list any other significant health problems ______________________________

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What was the date of your last physical examination? ______________________________

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