

Dermatology Associates of the South Bay
Amber Kyle, M.D. – Krishna Patel, PA-C
Hair Loss New Patient Visit

NAME: _____

DATE: _____

D.O.B.: _____

1. How old are you? _____
2. When did you start to notice that you were losing hair? Has it worsened?

3. Do you have family history of hair loss? _____
4. Have you tried anything for hair loss? _____
5. Did you start any medications around the time your hair loss began? _____
6. What medications are you taking currently? _____

7. Any recent surgeries, serious illness, or hospitalizations? _____
8. Any recent stressful events? _____
9. When was the last time you had your hormone levels checked? _____
10. How often, if at all, do you chemically process or straighten your hair? _____
11. Any changes to your diet? _____
12. Are you vegetarian? _____
13. **FEMALES:** Have you recently been pregnant? _____