

# Official ABHRS Clinical History Form

(To be filled out by the Examining Physician as completely as possible)

1. **Name:** .....
2. **Age:** .....
3. **Sex:**  Male  Female  Transitioning  Other.....
4. **Chief complaint:**  Hair loss  Ongoing Hair Shedding  Pain  Itching  Redness  Dandruff  Folliculitis/ Pustules  Others:  
.....  
Location:.....  
.....  
Onset:  Sudden  Gradual  
Patient Expectations.....  
.....
5. **History of present illness:**  
.....  
.....
6. **Past history:**  Diabetes  Hypertension  Cardiac Condition  History of Blood Transfusion  Bleeding Disorders  Seizures  Thyroid Disorder  Skin Disorders  Autoimmune Disorders  Others :  
.....
7. **Family History:**  
 Father's side  Mother's side  
Onset:  Sudden  Gradual ..... At the age of: .....  
Duration: .....
8. **Allergy (include reaction):**  Food  Drugs  Latex  Iodine  Metals  Tape  Others:  
.....  
.....  
.....  
.....



12.  Previous Hair loss treatment:  PRP  Photobiomodulation  Steroid Injections  Stem Cells  Others:

.....

13. **Review of systems:**

Central Nervous System:

.....  
.....

Respiratory System:

.....  
.....

Cardiovascular System:

.....  
.....

Endocrinal System:

.....  
.....

Gastrointestinal System:

.....  
.....

Musculoskeletal System:

.....  
.....

Renal System:

.....  
.....

Reproductive System:

Others:

.....  
.....

14. **Quality of Sleep:**  Poor  Average  Good

**Number of hours/day:**

.....  
.....

15. Nutritional Status:  Poor  Average  Good

Special Diet/Duration:

.....  
.....

Average weight lost last 12 months:

.....  
.....

16. For Females: Menstrual History  Regular  Irregular

Pain  Heavy Bleeding

Others: .....

Pregnant: Last day of menstrual period: .....

Menopause (At the age of: .....) )

17. Any History of:  Steroid Injections  Anabolic Hormones (Growth

Hormone/ Testosterone Hormone)  Whey Protein  Creatine

Monohydrate  Branched Chain Amino Acids

Other Supplementations: .....

Duration: .....

Reported side effects: .....

### 18. Examination

Overall Status:

Vitals: Height: ..... Weight: ..... BMI: .....

Vital Signs: Blood pressure: ..... Pulse rate: .....

Respiratory rate: ..... Temperature: .....

### 19. Scalp Examination:

Trichoscopic Findings:

Follicular & Hair Shaft Pattern:  Peri-Pilar Sign  Hair Diameter Variability

(Anisotrichosis)  Peri-Follicular Erythema

Peri-Follicular Scaling  Inter-Follicular Scaling

Yellow Dots  Black Dots  Exclamation Mark Hairs  Broken Hairs

Coiled Hairs  Corkscrew Hairs

Comma-Shaped Hairs  Flame-Shaped Hairs  Tufted Hairs  Greyish-

White Halos  V-shaped Hairs

Trichorrhexis Nodosa

Trichorrhexis Invaginata

**Exogenous Materials**

Artificial Hair Fibers

**Vascular Pigment Pattern:**

Arborizing Blood Vessels  Red Dots

Red Globules

Others: .....

Scars  Hypertrophic Scars  Keloids

Site: .....

Size: .....

**Previous Treatments:** .....

**Lesions:**  Tumors  Folliculitis/ Pustules  Abscess  Necrosis

Others: .....

Site: ..... Size: .....

Onset: .....

**Hair Characteristics:**  Caucasian  Afro  Asian

**Pull Test:**  Negative  Positive: Number of Hairs .....

Site:  Frontal  Occipital  Lesional

**Donor Area Characteristics:**

Hair Caliber: ..... Follicular Unit Density/cm<sup>2</sup>:

.....

Average number of hairs/ FU: ..... Hair Contrast:

.....

**Scalp Elasticity:**  Tight  Average  Hyperelastic

Mayer Paul's Elasticity Scale: .....

Presence of Retrograde Alopecia

Beard  Body Hair: (Check if available as donor).....

**Recipient Area Characteristics:**

Norwood Hamilton Grade: .....

Ludwig Grade: .....

Follicular Unit Density/cm<sup>2</sup>: .....

Recession of Temporal Hairline: Type: .....

Presence of grafted hair follicles from previous hair transplant surgery

**20. Lab tests:**  None  Previously Done

Relevant Lab work/Date:

.....

.....

.....  
.....

**21. Scalp Biopsy:**  None  Previously Done:

Number of Specimens: .....

Site of Specimens/Date:

.....  
.....  
.....

**Histopathological Report showing:**

.....  
.....

**22. Final Diagnosis:**

.....  
.....  
.....  
.....