Dermoscopy is a non-invasive diagnostic tool that permits recognition of morphologic structures not visible to the naked eye. Dermatologists involved in the management of and scalp disorders have discovered dermoscopy to also be useful in their daily clinical practice. Scalp dermoscopy or trichoscopy is not only helpful for the diagnosis of hair and scalp disorders, but it can also give clues about the disease stage and progression. Structures which may be visualized by trichoscopy include hair shafts of different types (vellus, terminal, intermediate, pathologic), follicular patterns (white, yellow, and black dots), vascular patterns, abnormalities of pigmentation, scaling, and exogenous materials. Using trichoscopy, signature patterns are seen in a range of scalp and hair conditions. Trichoscopic features of pattern hair loss (PHL) are diversity of hair shaft diameter, peripilar sign, and empty follicles, additional findings may be honeycomb pigment pattern, and arborizing red lines. Among the methods for diagnosis of PHL, the trichogram reflects low-grade telogen effluvium of the affected frontal and centroparietal scalp, while the trichoscopic finding of anisotrichosis relates to the presence of hairs with different caliber as a consequence of progressive hair follicle miniaturization. Originally Tosti et al suggested that diversity of hair shaft diameter > 20% is diagnostic of PHL. More recently, Rakowska et al proposed more sophisticated diagnostic criteria for diagnosis of PHL in women based on trichoscopic imaging. Major criteria are: (1) ratio of more than four empty follicles in four images (at 70-fold magnification) in the frontal area, (2) lower average thickness in the frontal area compared to the occiput and (3) more than 10% of thin hairs (< 0.03 mm in diameter) in the frontal area. Minor criteria were: (1) increased frontal to occipital ratio of single-hair pilosebaceous units, (2) vellus hairs, and (3) peripilar signs. Fulfillment of two major criteria or of one major and two minor criteria allow diagnosis of PHL in women with a 98% specificity. We performed a study to evaluate the value of trichoscopy as compared to the trichogram for the diagnosis of PHL in women, and found that trichoscopy is a valuable and superior method to the trichogram for diagnosis of PHL in women, especially in early cases, with the highest yield irrespective of the suggested cut-off of 20% diversity of hair shaft. Presence of peripilar signs might point to perifollicular microinflammation and fibrosis rendering PHL less responsive to standard treatment, while presence of honeycomb pigment pattern and of arborizing red lines relate to the extent of UVR exposure and possibly damage. Ultimately, examination of the scalp by dermoscopy can reassure patients with PHL that they have received a thorough scalp examination, since patients with hair loss are very distressed and often feel that they are not properly examined.