

Please complete this form if you have a nail related issue

## NAIL QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Were you born with this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No: When did you first have this problem?	
Which nails were affected first?	
Which nails are affected now?	
How has this changed from beginning until now?	
Describe your nails in general (hard, soft, brittle, etc.)	
Have you ever traumatised any of the nails involved, e.g. stubbed toes, hit nail with hammer, caught in door, etc.?	
Do you have any hobbies that could traumatise/damage or otherwise affect your nails, e.g. tennis, jogging, basketball, painting, playing piano?	
Did you in the past or recently do or have any of the following? <input type="checkbox"/> Pick, bite or suck <input type="checkbox"/> Tear nails off <input type="checkbox"/> Ingrown nails <input type="checkbox"/> Wear tight or pointed shoes <input type="checkbox"/> Push the cuticle back <input type="checkbox"/> Swelling around cuticles	
Personal nail care: List any nail cosmetics you use, e.g. base/top coat, enamel, nail strengtheners/hardeners, cuticle treatment.	
What instruments do you use to care for your nails? How often do you use them?	
Do you get manicures? How often?	
Have you ever had any of the following? How often? When was the last time? <input type="checkbox"/> Sculpted <input type="checkbox"/> False/Artificial/Gel Nails or Tips <input type="checkbox"/> Nail Wraps <input type="checkbox"/> Acrylic <input type="checkbox"/> Other	
Do you have, or have you had in the past, any other skin or hair problems? <input type="checkbox"/> Lichen Planus <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> "Jock Itch"/Thrush <input type="checkbox"/> Ringworm <input type="checkbox"/> Psoriasis <input type="checkbox"/> Yeast Infection <input type="checkbox"/> Other	
What treatment (self and professional) have you had for your <b>nail problem</b> ?	
Pills and dates used	
Topical treatments and dates used	
Surgical treatments and dates	
Does anyone in your family have any of the following? <input type="checkbox"/> Nail Problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Hard Skin <input type="checkbox"/> Hair or Skin Problems <input type="checkbox"/> Thyroid Problems	
What do you think is the cause of your nail problem?	