

Phoebe Rich Dermatology

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Nail Questionnaire

Name: _____ Age: _____ Sex: M or F Date: _____

Who referred you to our office? _____

Were you born with this nail problem? _____ If no, when did this problem begin? _____

What hand is your dominant hand? _____

Which nails were affected first?



(Mark with an x)

Which nails are affected now?

(Mark with a √)

What are your symptoms? (please circle all that apply)

Thickening Lifting Discoloration Ridges Pitting Pain Hot/Cold Sensitivity
Redness Growth/Lesion under the nail Cuticles Inflamed Bands/Stripes in the nail

How has this changed from onset to present?

Describe your nails in general (hard, soft, brittle, etc.) _____

Have you ever traumatized any of the involved nails? (Stubbed your toe, hit the nail with a hammer, caught in a door, etc.) _____

What kind of work do you do? _____

Do you do anything to affect your nails or the tips of your fingers or toes? (hobbies, typing, dishwashing, sports, knitting, gardening, etc.) _____

Do you have contact with any chemicals or irritants such as strong soaps, hair color/straightening chemicals, dyes, wet work, etc.?

Have you in the past or recently done any of the following? (please circle all that apply)

Pick at your nails Bite/suck your nails Wear tight or pointed toe shoes Push the cuticle back
Tear your nails off Ingrown nails Hangnails/inflammation of the cuticle

Personal nail care:

Do you go to a manicurist? _____ How often? _____ What is usually done? _____

List any cosmetics or conditioners that you use including: Base coat, top coat, polish removers, enamel/nail strengtheners, cuticle treatments, hand creams, glues, acrylics, shellac, or gels?

Do you have any other skin or nail related problems, or have you ever in the past? (circle all that apply)

Jock itch Psoriasis Athlete's foot Thyroid problems Anemia Lichen Planus Ringworm
Yeast Infections Patchy Hair Loss Diabetes Melanoma Basal Cell or Squamous Cell Carcinoma
Bleeding Problems Other _____

Do you have a history of related problems in the following areas?

Eyes Ears Nose Throat Lungs GI tract Urinary tract Blood Muscular/Skeletal
Neurological Hormones Heart Immune System

Describe your hair (coarse, thick, thin, fine, sparse, etc.)

List all medication that you have taken within the last year that you are NOT currently taking:

What treatments have you tried for your nail problem (past and present):

Does anyone in your family have nail problems, diabetes, thyroid, skin problems, or patchy hair loss?

What do you think is the cause of your nail problem? _____

Is there anything else you would like us to know? _____
