Nathaniel J. Jellinek, MD
Mohs Surgery
Nail Diseases

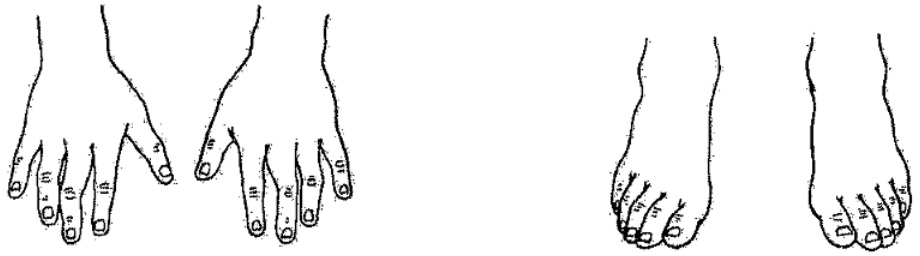
New nail patient questionnaire

YOUR NAME:_____ DATE:_____

What is your nail problem? _____

When did this problem start? _____

Which nails are involved? (circle these)



RIGHT LEFT RIGHT LEFT

Have you ever traumatized any of the involved nails (stubbed your toe, hit the nail with a hammer, etc.)? □ yes □ no

Contact with chemicals or irritants, such as strong soaps, hair straighteners, lye, etc.? □ yes □ no

Did you in the past or have you recently (circle all that apply):

Pick at your nails **Bite or suck your nails** **Ingrown nails** **Wear tight or pointed-toe shoes** **Push the cuticle back**

PERSONAL NAIL CARE

Circle any nail products that you use: **Nail polish** **Nail hardeners** **Cuticle treatment** **Nail conditioners**

Others (please list): _____

List any instruments that you use to care for your nails (file, buffer, orange stick, etc.):_____

Do you go to a manicurist? □ yes □ no How often?_____

Which of the following have you had? (circle all that apply) **Gel nails** **Shellac nails** **Acrylic nails** **Other:** _____

Circle any other skin or hair problems that you ever had any in the past? (circle all that apply)

lichen planus **psoriasis** **ringworm** **"jock itch"** **athlete's foot** **eczema**

PAST MEDICAL HISTORY

List any medical problems that you have had in the past or have now (diabetes, heart trouble, thyroid problem, etc.)

_____ _____ _____

_____ _____ _____

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List any medications that you have taken during the last year (include herbs and supplements)

Medication	Dose	How many times a day	Medication	Dose	How many times a day

List any drug allergies

_____ _____ _____

What treatment (self and professional) have you had for your nail problem (past and present)?
a. List pills and dates used:

b. List topical treatments and dates used:

c. List surgical treatment and dates performed:

Does anyone in your family have any of the following? (Circle all that apply)

Nail problems **Melanoma** **Thyroid problems** **Skin problems (psoriasis, lichen planus, fungus, etc.)**

Review of Systems

PLEASE CIRCLE ALL THAT APPLY

<table>
<tr>
<td>General/skin/sleep
• Δ weight
• Fatigue/Weakness
• Fevers/Chills
• Other: _____</td>
<td>Respiratory
• Cough
• Short of breath
• Wheezing/Asthma
• Other: _____</td>
<td>Musculoskeletal
• Joint pain/back ache
• AM stiffness
• Arthritis
• Other: _____</td>
<td>Endocrine
• Thyroid problems
• Diabetes
• Other:
_____</td>
</tr>
<tr>
<td rowspan="2">HEENT
• Eyes: o Vertigo
• Ears: o Tinnitus
o Vertigo
• Nose
o Nosebleed
o Sinus
o Other:
_____
• Mouth/ Throat:
o Other:
_____</td>
<td>Cardiovascular
• Edema
• Deep vein thrombosis
• Easy bruise/bleed
• Anemia
• Other: _____</td>
<td colspan="2">Neuro/psych
• Numbness/tingling
• Tremor/coordination
• Anxiety/tension/stress
• Depression/tearfulness
• Other: _____</td>
</tr>
<tr>
<td>GI
• Δ appetite
• Nausea/Vomiting
• Abdominal Pain
• Jaundice/hepatitis
• Other: _____</td>
<td>GU
Other:
_____</td>
<td>ID
• Staph infection
• MRSA infection
• Herpes infection
• Fungal infection
• Hepatitis B/C
• HIV
• Other:</td>
</tr>
</table>

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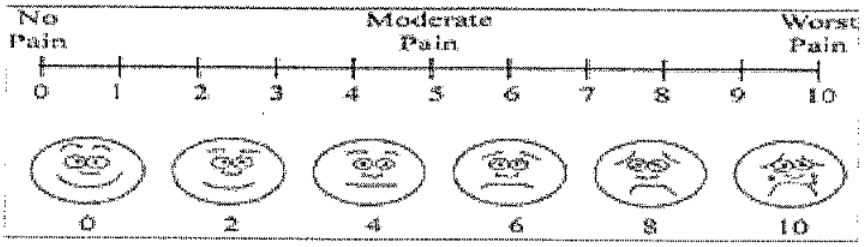
Do you have a history of Melanoma? *NO* *YES* When _____ Where (location on body) _____
Stage/thickness if known _____
Treatments _____
Who has treated you for Melanoma? _____
Do you have a full skin check scheduled due to your history of Melanoma? *NO* *YES* When? _____

Primary care physician: _____

Referring physician: _____

Occupation: _____

Are you having any pain today? *NO* *YES* If yes, please circle level of pain



Do you smoke? *YES* How much? _____pack/s a day. *FORMER SMOKER* Quit when? _____ *NEVER SMOKER*

Do you drink alcohol? *NEVER* *OCCASIONALLY* (socially or weekends only) *DAILY* How much daily? _____

Have you had the Pneumonia vaccine? *NO* *YES* When _____

Have you had the Flu Vaccine? *NO* *YES* When _____

Do you have a history of psoriasis or psoriatic arthritis? *NO* *YES*
If yes, have you been tested for TB? *NO* *YES* When? _____ Result? _____

Do you have an Advanced Care Plan or Surrogate Decision Maker? *NO* *YES* Name _____

What pharmacy do you use? _____