

**PATIENT QUESTIONNAIRE  
MYCOLOGY**

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**Patient's Name:**

**DOB or NHI:**

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**Please write or circle appropriate answers**

**Site of collection:**

1. Have you been given any anti-fungal treatment for this?  
Creams: \_\_\_\_\_ Tablets: \_\_\_\_\_ Last applied: \_\_\_\_\_
2. Do your nails (fingers or toes) have any of the following appearance?
  - Discoloured nails: What colour? (a) Black (b) White spots (c) Other \_\_\_\_\_
  - Thickened nails
3. Are the soles of your feet: (a) blistered, or (b) pitting?
4. Do you have any change to the colour (pigment) of your skin? YES / NO  
If yes, please provide details: \_\_\_\_\_

**Collection Staff:** Please indicate on picture where specimens were taken from

