Finger Lakes Dermatology

New Patient Health Questionnaire

Please complete in ink and return to the receptionist when complete. Thank you!

Last Name: _____ First Name: _____ DOB: _____

Race/ Ethnicity (please circle all that apply)

Black or African American, American Indian or Alaska Native, White,
Hawaiian Native or Pacific Islander, Hispanic or Latino, Do not wish to answer

Gender: (please circle) M / F Do not wish to answer

Referred by: _____

Reason for visit: _____
_____
_____

Other Symptoms? (Please circle all that apply)
Fever Headaches Rash N/V Diarrhea Abdominal Pain Joint Aches Chest Pain
Shortness of Breath Bleeding Disorder Sore Throat Cough

Current Medications:
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies:
_____
_____
_____

Habits: (Circle)
Smoker: Y N Quit

Pharmacy:
_____

Surgeries/Operations: _____
_____

Pacemaker/Defibrillator: Yes or **No**

Personal Health History: (Please circle)
Eczema Psoriasis Arthritis High Cholesterol Hepatitis
Keloids Kidney Disease Diabetes High Blood Pressure
Cancer (if yes what type) _____
Other:_____

Personal History of Skin Cancer: Y or **N (if yes please list type and locations)**
_____

Family History of Melanoma: (Please circle) Mother Father Son Daughter Other_____

Family History of Skin Disease: (Please circle) Lupus Dermatomyositis Other_____

Have you had the Pneumonia vaccine (65 or older): Yes or **No**

Did you get the Influenza vaccine this year: Yes or **No**

Do you have a Healthcare Proxy: Yes or **No**

Do you have a Living Will: Yes or **No**