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: _____
Home/Cell Phone Number: (____)_____-_____ Ok to leave message? Yes No
Referred By: _____
Current Symptoms/Complaints (Duration and Location) _____
_____
_____

Other Symptoms? (Please circle all that apply)
Fever Headaches Shortness of Breath Muscle aches/Pains Weakness Fatigue
Cough Nausea/and or Vomiting Easy Bleeding/Bruising Visual Changes
Joint Pain Chest Pain Leg Swelling Weight/Appetite Changes Constipation
Diarrhea Tingling/Numbness of extremities

Current Medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies:
_____
_____
_____

Habits: (Circle)
Smoker: Y N Quit
Alcohol Use: Y N
Drug Use: Y N

Pharmacy:
_____

Pacemaker/Defibrillator: Yes or **No**

Surgeries/Operations: _____
_____

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

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_____