

# New Patient Questionnaire

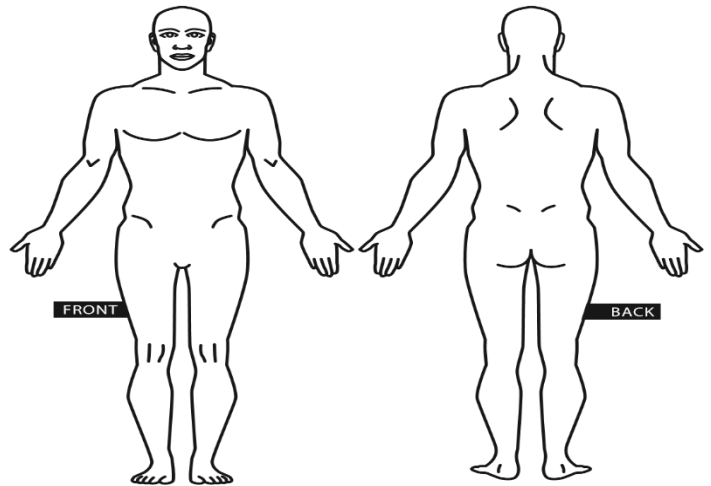
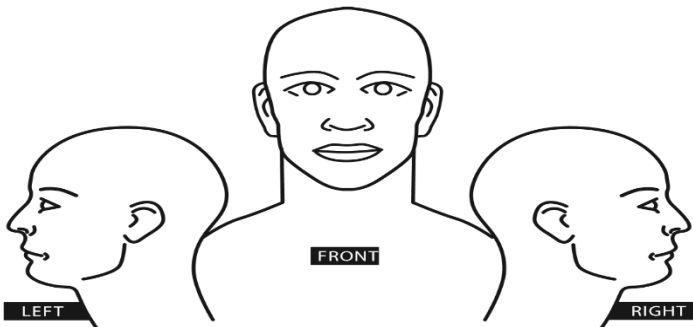
I understand the doctor may apply fees for Skin Clinic Visits: **Yes / No**

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Do you currently have any Spots or Lesions of Concern? **Yes / No (if Yes mark below)**

Please mark (X) on the following diagrams the spots / lesions that you are worried.



2. Have you previously had any forms of Skin Cancer? **Yes / No**
3. Do you have Family History of Melanoma? **Yes / No**
4. Do you have a Pacemaker/Defibrillator? **Yes / No**
5. Do you have Hepatitis, HIV or Diabetes? **Yes / No – If Yes: \_\_\_\_\_**
6. Are you taking any Medication or blood thinners? **Yes / No – If Yes: \_\_\_\_\_**

To check your skin thoroughly, the doctor will ask you to remove your outer clothing leaving on your undergarments. If you require your doctor to examine areas within your undergarments, please discuss this with your doctor.

## I consent to: (please tick)

( ) A full skin cancer check (excluding skin within undergarments), I undertake to follow up my pathology results by telephone and make necessary appointments. I take responsibility for any unchecked areas. I understand my doctor will charge an out-of-pocket fee for today's appointment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_