

Proactive Health Solutions
Patient Information Sheet

For Office Use Only

LA SCMC TLC SDWC

Name: (last, first) _____

DOB: _____
(mm/dd/year)

Address: _____

Email: _____

Preferred phone: _____

Please circle one.

Have you had caffeine in the past 4 hours?..... Yes No

Have you smoked in the past 2 hours?..... Yes No

Have you applied lotions, powder, or deodorants
in the area being scanned?..... Yes No

Have you had any sun exposure to the area of concern?..... Yes No

Please list current medications:

If you would like a copy of this report sent to your current MD, please include complete address:

Physician's Name _____

Physician's Address _____

Signature

Date

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