Annual Health Assessment

F-00000711

Patient Information

Field	Value
First Name	Carole
* Last Name	White
Date of Birth	10/26/1975
Phone	8888888888
Email	info@salesforce.com
* Do you have access to reliable transportation?	No

Please provide your primary address

Field	Value
Street	2199 South University Boulevard
City	Denver
State	CO
Zip	80210

Skin Exam

Field	Value
* Dermatology Concerns	Suspected
* Is the mole, spot, or growth larger than 1/4 inch in diameter?	Yes
* Has the patient noticed a change in size/shape/color/elevation in the past 6 months?	Yes

Please take a photo of the mole, spot, or growth for recognition: FILE: 2_11_2019_1-26-58pm (300 KB)

Patient Medication

Medication: Robax

Dosage: 3.0

Route: Oral

Health Conditions

Asthma: No

Diabetes:

Depression: No

Overall Health and Wellness

* Do you have a prescription delivery service?

◉ No
○ Yes

* How do you feel about the quality of care you receive from your Primary Care Physician?

I'm very pleased with the care I receive from my primary care physician.