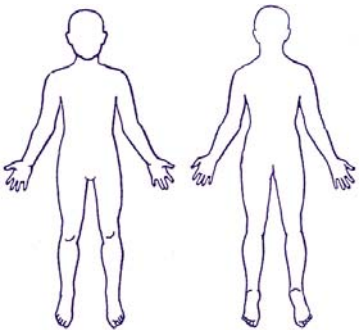
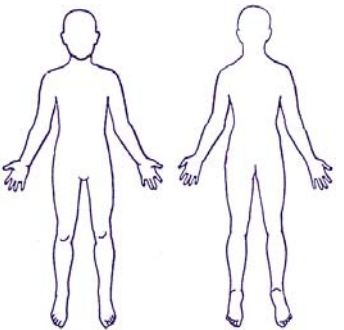
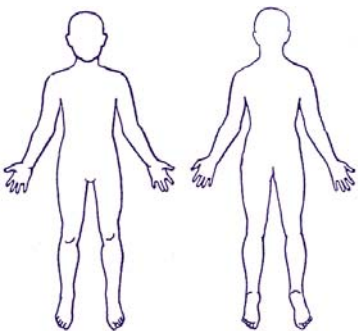
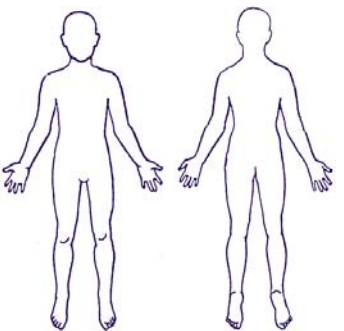


Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Lesion 1</b> 	<b>Lesion Location:</b> _____ <b>Lesion Type:</b> _____ <b>Lesion Height:</b> _____ <b>Diameter:</b> _____	<b>Lesion 2</b> 	<b>Lesion Location:</b> _____ <b>Lesion Type:</b> _____ <b>Lesion Height:</b> _____ <b>Diameter:</b> _____
<b>Freeze Time:</b> _____ <b>Pen Tip Size:</b> _____ mm <b>Return Visit:</b> _____	<b>Diagnosis:</b> _____	<b>Freeze Time:</b> _____ <b>Pen Tip Size:</b> _____ mm <b>Return Visit:</b> _____	<b>Diagnosis:</b> _____

<b>Lesion 3</b> 	<b>Lesion Location:</b> _____ <b>Lesion Type:</b> _____ <b>Lesion Height:</b> _____ <b>Diameter:</b> _____	<b>Lesion 4</b> 	<b>Lesion Location:</b> _____ <b>Lesion Type:</b> _____ <b>Lesion Height:</b> _____ <b>Diameter:</b> _____
<b>Freeze Time:</b> _____ <b>Pen Tip Size:</b> _____ mm <b>Return Visit:</b> _____	<b>Diagnosis:</b> _____	<b>Freeze Time:</b> _____ <b>Pen Tip Size:</b> _____ mm <b>Return Visit:</b> _____	<b>Diagnosis:</b> _____

Notes: \_\_\_\_\_

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Were any lesions itching, bleeding, painful, recently changing, or located in a problem area?