Lesion/Growth/Cyst Questionnaire

Patient Name : _____ DOB _____

	Lesion #1	Lesion #2	Lesion #3	Lesion #4
Location of lesion/cyst/stye/ abnormality?				
When did you first notice this?				
Is it itchy?				
Is it painful?				
Does it bleed?				
Any recent change in shape or color?				
Is it growing?				

Do you have a history of skin cancer? Y___N___

What type? _____

How many have you had and where? _____

_____

_____

_____

_____

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_____

Patient Signature _____ Date: _____