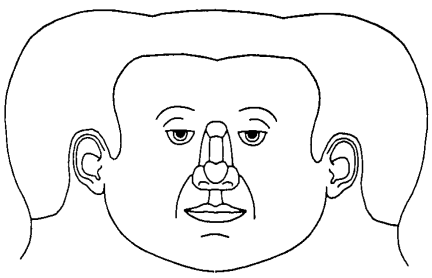
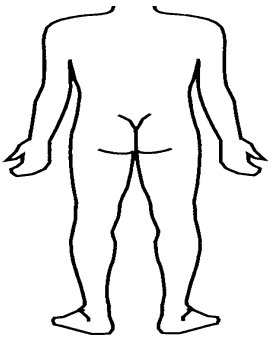
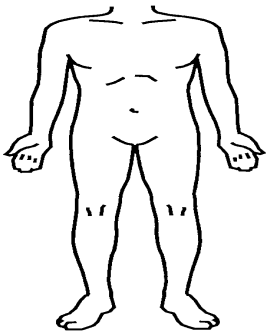
Spot Check History Form

Name: Date of Birth: Date of Visit:







Problems / Lesions	1	2	3	4	5
Acne Spot Mole Wart Growth Rash Itching or Other Problems, Please List:					
Location / Site Generalized Localized If Localized, List Sites affected:					
Timing / How did it happen? Onset: Sudden Gradual Status: Acute Persistent Recurrent Stays or Comes & Goes					
Duration / When did it occur? How long? When did it start? Days Weeks Months Years					
Severity Mild Moderate Severe Extensive					
Quality No-Symtoms Itching Irritating Painful Non-healing Changing Suspicious Bothersome Upsetting Unsightly					
Context Any Special Triggers? None, Unknown or List:					
Associated Signs & Symptoms Itching Pain Weakness Numbness Abnormal Sensation None or Other list:					
Modifying Factors A & B					
A: Condition aggravated by: Nerves Stress Menses Work Contact Allergy Plants Chemicals Sports Hobbies Pets Drugs None Unknown Others list:					
B: Condition relieved by: None Unknown Medications Drugs Home-remedies OTC-Drugs Others list:					