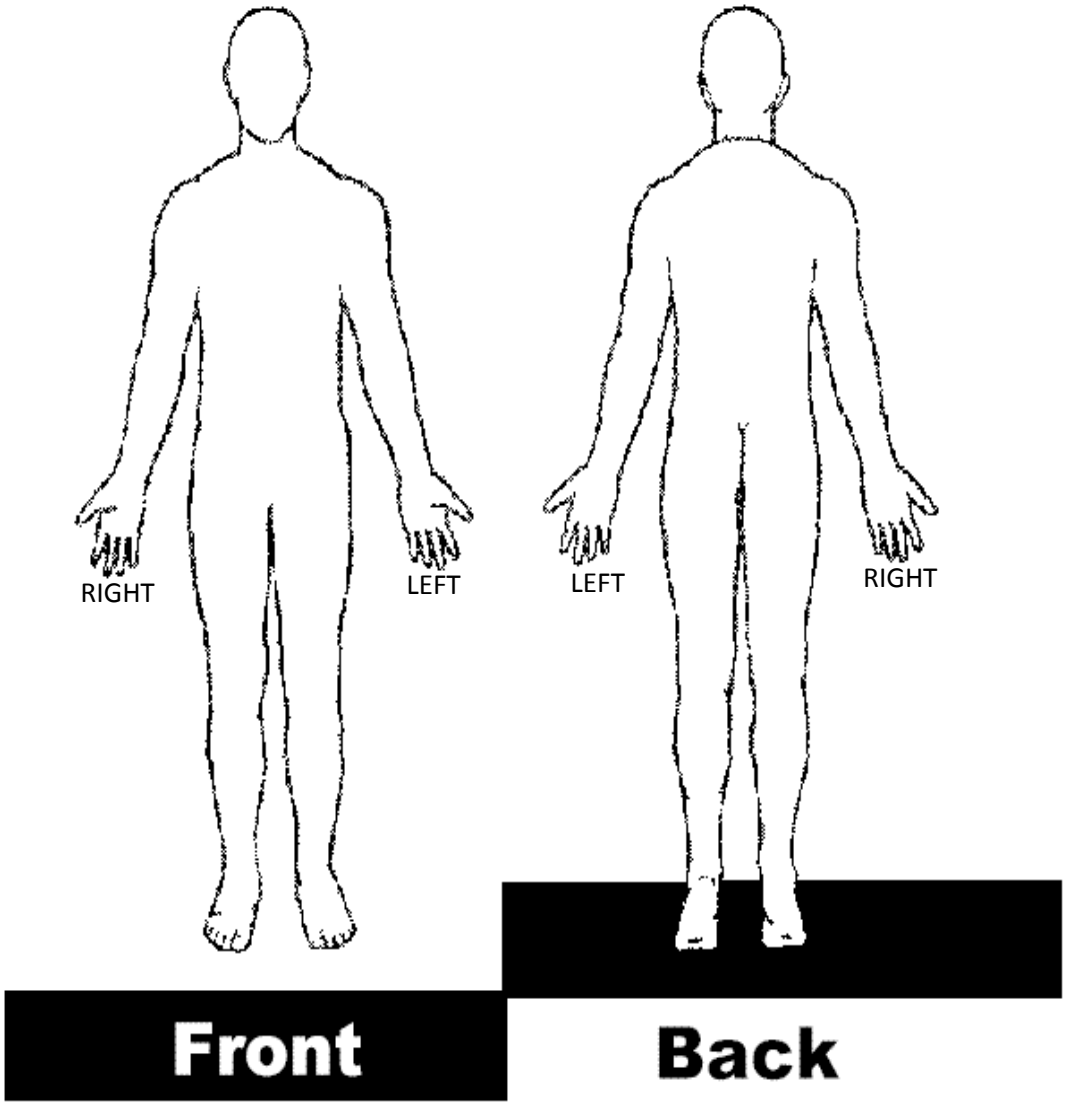
PROCEDURE SITE



PLEASE MARK WITH A PEN THE SITE(S) WHICH IS BEING TREATED BY THE PHYSICIAN TODAY

Circle Pain Level (0 = No Pain – 10 = Worst Pain): 0 1 2 3 4 5 6 7 8 9 10

Are you diabetic? **YES / NO** Are you on blood thinners? **YES / NO** If yes, when stopped _____

Are you post-menopausal? **YES / NO** Have you had a hysterectomy? **YES / NO**

---------- DO NOT WRITE BELOW DOTTED LINE ----------

LAB RESULTS (if applicable):

HCG: **NEG / POS** BLOOD GLUCOSE: _____ mg. / dl

PHYSICIAN SIGNATURE: _____ DATE: _____TIME: _____

PATIENT LABEL