Please complete the following information so that we may capture pertinent information for the most comprehensive evaluation of your imaging today.

Age/Gender:

Referring Physician or Self:

Clinical Concerns (What brings you today):

Current Symptoms & When Did They Begin:

Current Treatments:

Current Medication/Supplements (name/dosage):

(back)

(Cont.)

Have you Had Previous Thermography Scans/When was your last:

Female Only:
When was your last Mammogram/Results:

Result of Clinical Results: (i.e. surgery, biopsy, monitor, sonogram):

Surgeries (Type/Date):

Dental History:

General Health Issues/Conditions (i.e. HBP, Diabetes, etc):

Family History:

Skin Lesions or Physical Abnormalities (i.e. scars, implants, scoliosis, pumps/ports):