A Picture of Health Thermograms
Patient Information Sheet

Name .....D.O.B. .....

Address .....

City.....State.....Zip.....

Phone (H) ..... (W/C) .....

Email Address .....

Would you like us to send your report to you via email? Yes No

Occupation .....

Previous Illnesses .....

.....

Previous Surgery .....

.....

.....

Current Health Problems .....

.....

.....

.....

Medications .....

.....

.....

Other Treatment .....

.....

Current Doctor .....

Do you want a copy of the thermogram report forwarded to your doctor? Yes.....No.....

If no, you are agreeing to hand-carry a copy to him/her.

If yes, please provide an address or email address of your doctor.

....

This information is confidential.

All information is correct to my knowledge.

Signed ..... Date .....

Name _____ Date:_____

Patient Review of Body Systems

Constitutional

___ Fevers/Chills/Sweats

___ Unexplained weight loss/gain

___ Fatigue/weakness

___ Excessive thirst or urination

Musculo-Skeletal

___ Muscle/Joint Pain

Ear/Nose/Throat

___ Difficulty hearing/ringing

___ Hay fever/Allergies

Cardiovascular

___ Chest Pain/Discomfort

___ Leg Pain w/Exercise

___ Palpitations

Other (please specify)

_____

_____

_____

Dental

___ Extractions

___ Crowns

___ Root Canal

___ Gum Disease

___ Fillings

___ Other

Respiratory

___ Cough/Wheeze

___ Difficulty Breathing

Gastrointestinal

___ Heartburn/Reflux

___ Nausea/Vomiting/Diarrhea

___ Large bowel dysfunction

___ Abdominal Pain

Skin

___ Rash or Mole

Neurological

___ Numbness

___ Headaches

Organ Dysfunction

_____

_____

Blood/Lymphatic

___ Unexplained Lumps

___ Easy Bruising

General Medical History: Past and Current medical problems (please indicate dates)

___ Heart Disease (specify)

___ Diabetes

___ Asthma/Lung Disease

___ Accidents

___ Other (Specify)

__ High Blood Pressure

___ Thyroid Problem

___ Chemical Exposure

___ Injuries

___ High Cholesterol

___ Kidney Disease

___ Cancer (specify)

_____

_____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___ High Cholesterol

___ Heart Disease

___ Bleeding or Clotting

___ Asthma/COPD

___ Cancer

Type_____

___ High Blood Pressure

___ Stroke

___ Genetic Disorders

___ Other

_____

_____

___ Diabetes