CLIENT INFORMATION

Today's Date: First scan? Y N

Tech use only	THERM: Base1 Base2 Annual Comp FULL UPPER LOW BR ROI QMSA: INITIAL COMP SP

Name: _____ Date of Birth: _____
FIRST MIDDLE INITIAL LAST

Address: _____
STREET ADDRESS CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____ Call Preference: Home / Cell

Email: _____

Referred by: _____ Doctor _____ Send report to doctor? _____

☐ Male ☐ Female **If female:** # pregnancies?_____ # births?_____

Directions: You do not need to duplicate information filled out on other forms. Answer questions that pertain to you

List below your four main health complaints in order of importance:

1) _____

2) _____

3) _____

4) _____

Current Medications, supplements and treatments (dose/frequency) _____

_____

_____

_____

_____

Current Diagnoses: _____

_____

History/Date: Surgeries, Injuries, Chronic conditions: _____

_____

_____

_____

_____

Clinical correlation to previous scan, mammogram or other tests: _____

Check all that apply:

Family History/Relationship:

- ☐ Cancer FATHER / MOTHER / SIBLING GRANDPARENT / OTHER
- ☐ Diabetes FATHER / MOTHER / SIBLING GRANDPARENT / OTHER
- ☐ Heart Disease FATHER / MOTHER / SIB GRANDPARENT / OTHER
- ☐ Other: _____

Personal History:

- ☐ Endometriosis
- ☐ Ovarian/breast cysts
- ☐ Cervical Cancer
- ☐ Hysterectomy __ partial __ full
- ☐ Vasectomy
- ☐ History of Cancer Type: _____
- ☐ Current Dx Cancer Type: _____
- ☐ Heart Attack or Stroke
- ☐ Pacemaker
- ☐ Dental Implants/root canals
- ☐ Immune System Dx
- ☐ Bloodthinner Rx
- ☐ Cholesterol Rx
- ☐ Anti-depressant Rx
- ☐ Antacid use
- ☐ Hormone Rep Therapy
- ☐ Birth Control
- ☐ Breast Implants

For Thermographic evaluation:
Describe location of tattoos, major scars, amputations, skin/body notations :

_____

_____

_____

PATIENT DISCLOSURE FOR THERMOGRAPHIC AND/OR MSA TESTING:

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic or electrodermal findings discussed in the Report(s).
I understand that Medicare does not cover this test. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature _____ **Date** _____