Thermography Patient Information Sheet

Name_____ D.O.B_____

Address_____

Phone (H)_____ (C)_____

Email address_____

Occupation_____

Previous Illnesses:

Previous Surgery:

Current Health Problems:

Medication_____

Other Treatment_____

Current Doctor_____

Do you want a copy of the thermogram report forwarded to your doctor? Yes___ No___

Were you referred to us? Yes___ No___ Name of person or group who referred you_____

May we thank them? Yes___ No___

This information is confidential. All information is correct to my knowledge.

How do you want to receive your report? Circle one: Email, CD, Print.

Signed_____ Date_____