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: ______________________ (FIRST MIDDLE INITIAL LAST) Date of Birth: __________

Address/city/st/zip: ______________________

Home Phone: __________ Cell Phone: __________ Call Preference: Home / Cell

Email: ______________________

Referred by: __________ Doctor __________ Send report to doctor? ______

☐ Male ☐ Female ☐ Sex change? **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
- ☐ HIV
- ☐ 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 :

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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** __________