THERMOGRAPHY OF HOUSTON
See Yourself in a New Way!

FOR OFFICE USE ONLY
Pt ID #: _____ Rpt #: _____
BR2 BA HB FB ROI - URGENT - INV
EM-C (PW: text / call) - M-C / M-D - LOC:_____

Returning Patient Information Sheet

Name: _____ Date:_____

Has your contact information changed since we saw you last? Y N *If so, provide below:*

Address _____ Cell Phone _____

City, State, Zip _____ Alt. Phone _____

Email address _____ Age _____

Current Health Concerns _____

Troublesome Symptoms _____

What Aggravates Them/Relieves Them _____

Any Treatment for This Condition _____

Current Doctor and Type _____

Medications (including prescribed, hormones, and over the counter) _____

_____

Has this changed since we saw you last? ❑ Yes ❑ No

Date of your last clinical breast exam: _____ Results: _____

Date of your last mammogram: _____ Results: _____

Date of your last breast ultrasound: _____ Results: _____

Date of your last breast MRI: _____ Results: _____

Any major illness since last scan? _____

Any surgery since last scan? _____

Anything else you think is important for us to know? _____

Have you had a vaccine in the past 4 weeks? ❑ Yes* ❑ No

*If yes, date: _____ Which arm? ❑ Right ❑ Left

How would you like to receive your report? Email to Me Mail to Me Send to My Doctor*

**If sending to your doctor, please provide the following:*

Doctor's Name _____ Doctor's Phone # _____

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

Signed _____ Date _____

Printed Name _____