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 _____

UPPER BODY QUESTIONNAIRE

Please chose Y for Yes and N for No on the following questions:

HEAD & NECK

Y N Do you suffer with headaches? If yes, how often?_____

Y N Do you have allergies? If yes, to what? _____

Y N Do you have: ❑ TMJ OR ❑ Jaw clicks when chewing

Y N Do you currently have a cold?

Y N Are you being treated for a thyroid disorder? If yes, how? _____

Y N Do you have neck pain? If yes, describe _____

Y N Do you have a history of carotid artery disease?

Y N Do you have a family history of stroke?

Y N Do you currently suffer with sinus problems?

Y N Do you have any: ❑ dental crowns/caps ❑ root canals ❑ metal amalgams ❑ dental implants

If yes, list where these are in your mouth:_____

Y N Do you have: ❑ Gum disease ❑ Receding gums ❑ Bleeding gums

BREAST & CHEST

Y N Have you ever been diagnosed with ❑ Heart Disease

If yes, please list diagnosis: _____

Y N Do you suffer with chest pain? If yes, describe _____

Y N Have you ever had surgery in the following area: ❑ Heart

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

BACK

Y N Do you have pain in the following areas:

❑ Upper Back ❑ Lower Back

If yes, describe pain(s) _____

Y N Do you have: ❑ Asthma OR ❑ Shortness of breath

Y N Do you currently smoke?

Y N Have you smoked in the last 5 years?

Y N Have you ever been diagnosed with: ❑ Lung Disease ❑ Mid to Upper Spine Disorders

If yes, please list diagnosis: _____

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

❑ Lungs ❑ Mid to Upper Back ❑ Lower Back ❑ Kidneys

If yes, list surgery/condition and when _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

UPPER BODY QUESTIONNAIRE, Continued…

ABDOMEN

Y N Do you suffer from acid reflux? If yes, how often _____

Y N Do you have pain in the following areas:

❑ Stomach ❑ Abdomen (upper/lower) ❑ Below Right Breast

If yes, describe pain(s) _____

Y N Do you experience:

❑ Constipation ❑ Diarrhea ❑ Bloating ❑ Indigestion

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

❑ Stomach ❑ Spleen (upper left) ❑ Liver (upper right) ❑ Intestines ❑ Abdomen

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____

ARMS & HANDS

Y N Do you have pain in the following? If yes, describe pain(s) _____

❑ Shoulder RT LT ❑ Elbow RT LT

❑ Arm RT LT ❑ Hands RT LT

Y N Have you had surgery or suffered with a condition (tear, broken bone, etc.) in the following?:

❑ Shoulder RT LT ❑ Elbow RT LT

❑ Arm RT LT ❑ Hands RT LT

If yes, list surgery/condition and when: _____

Y N Do you have any special concerns or details related to the information given above? If so, please list:

_____