Current Health Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name: _____ Birthdate: _____

Please make notations as related to the area(s) for which this study is being performed.

Please Show areas of :

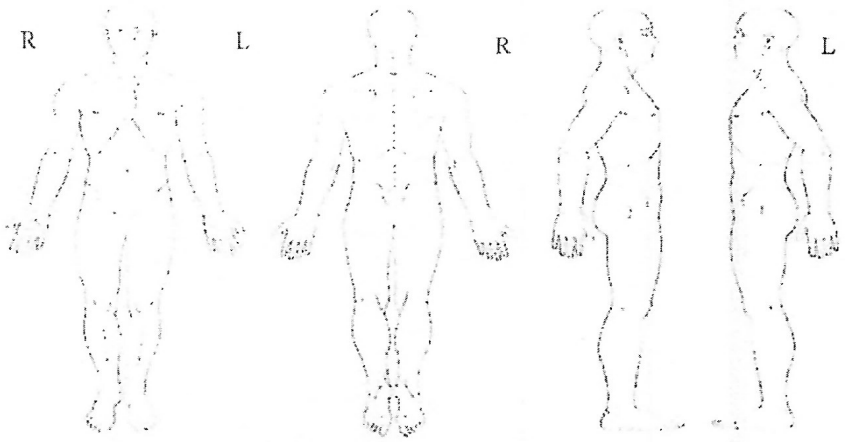
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring/ piercing



Health History: Note "C" for current conditions you have or "P" for those in the past

□ Head Region:
___ Migraine Headaches
___ Sinus Problems
___ Cataracts
___ Glaucoma
___ TMJ - R / L
___ Ear Infection
___ Hearing Loss
___ Tinnitus
___ Other

□ Neck Region
___ Thyroid (Hypo/Hyper)
___ Carotid Arteries Narrow
___ Sore Throat (on scan date)
___ Other

□ Lungs
___ Asthma
___ Bronchitis/Pneumonia
___ COPD/Emphysema
___ Cold/Flu (on scan date)
___ Emphysema
___ Tuberculosis
___ Other

□ Vascular
___ Blood Clots
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Pacemaker
___ Poor Circulation
___ Stroke
___ Vascular Disorder
___ Varicose Veins
___ Other

□ Digestive Disorders
___ Gastric Reflux
___ Indigestion
___ Irritable Bowel Syn
___ Diverticulitis
___ Polyps
___ Ulcers
___ Frequent Urination
___ Colonoscopy
___ Other

□ Skin
___ Acne
___ Rash
___ Other

□ Other Organs
___ Adrenal Stress
___ Kidney Disease
___ Liver Disease
___ Hepatitis
___ Other

□ Muscular/Skeletal
___ Arthritis
___ Carpel Tunnel R or L
___ Herniated Disk
___ Joint Degeneration
___ Nerve Damage
___ Osteoporosis/penia
___ Other

□ Female
___ Hot Flashes
___ Hysterectomy
___ Ovarian Fibroids
___ Uterine Fibroids
___ Vaginal Infection
___ Other

□ Males
___ Prostate Problem
___ Vasectomy
___ Other

□ Anemia
□ Allergies
□ Cancer/Tumors/Growths
□ Diabetes
□ Epilepsy
□ Fibromyalgia/CFS
□ Gout
□ Hernia
□ Multiple Sclerosis
□ Parkinson's Disease
□ Prosthesis
□ Shingles
□ Other _____
_____
_____

□ Dental
Last Visit_____
_____

Root Canals # _____
Extracted Teeth: _____
Partials ___Upper __ Lower
Permanents ___ Y ___ N
Amalgams Removed? _____
Chew gum regularly? _____
Braces (age)? _____

Primary reason(s) for having a Thermography Scan / Clinical Concerns:

Patient Disclosure

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 bus 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 findings of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature: _____ **Date:** _____