



PATIENT INFORMATION SHEET

This information is confidential.

NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION: _____

Previous Illness:

Previous Surgery:

Current Health Problems:

Medication: _____

Other Treatment: _____

Physician: _____

Address: _____

Phone: _____

Do you want a copy of the thermogram report forwarded to your physician: Yes: _____ No: _____

All information is correct to my knowledge.

Signed: _____ Date: _____