Thermography of Wisconsin - Patient Information

Name ____________________________________

DOB _______________ **Age** ______**Gender**____

Street ____________________________________

City ______________________________________

State, Zip _________________________________

Occupation ______________________________

E-mail ____________________________________

For office use only

Patient ID# ____________ Next Appt ________

Report Ref # ____________ BR1 BR2 BRA WHC FB ROI

Referred by _________________________________

Location ____________________________________

Date updated ________________________________

Sub _____ Prt rpt sent _______ HCP rpt sent _______

Pymt ________ CA/CC#/Ck# ________

Phone (please include area code) (H) ________________________ **(W)** _______________________

(C) ________________________ **Leave Message? Yes / No** **Text OK? Yes / No**

Referring Physician:________________________

Reason for today's visit/clinical concerns: ____

Current symptoms: ____

____

Current treatment: ____

Current medication(s): ____

Current supplement(s): ____

Previous illnesses: ____

Previous surgeries/Dates: ____

Dental history/Dates:____

Vaccine history: ____

General health history: (See Systems on reverse)

Skin lesions or physical abnormalities: ____

OB/Gyn history: ____

Do you want your report sent to your Health Care Provider? (circle one) Yes No

If yes, name and mailing address/email address of <u>one</u> Provider: ______________________________________

____

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

Signed: ____ **Date:** ______________________

Name ______________________________________ Date______________

Review of Systems

Constitutional

___Fevers/Chills/Sweats

___Unexplained weight loss/gain

___Fatigue/weakness

___Excessive thirst or urination

Musculo-Skeletal

___Muscle/Joint Pain

Ears/Nose/Throat

___Difficulty hearing/ringing

___Hay Fever/Allergies

Cardiovascular

___Chest Pain/Discomfort

___Leg Pain w/Exercise

___Palpitations

Dental

___Extractions

___Crowns

___Root Canal

___Gum Dis

___Fillings

___Other

Respiratory

___Cough/Wheeze

___Difficulty Breathing

Gastrointestinal

___Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Abdominal Pain

Skin

___Rash or Mole

Neurological

___Numbness

___Headaches

___Dizziness

___Memory Loss

___Loss of Coordination

Blood/Lymphatic

___Unexplained Lumps

___Easy Bruising

Eyes

___Change in Vision

Psychiatric

___Anxiety/Stress

___Problems with sleep

___Depression

Other (please specify) ____

General Medical History: Past and Current medical problems (please include dates)

___Heart Disease: (specify) ________________

___Asthma/Lung Disease

___Accidents

___High Blood Pressure

___Diabetes

___Chemical Exposure

___Injuries

___High Cholesterol

___Thyroid Problem

___Kidney Disease

___Other: (specify)

___Cancer: (specify) ____

Family History: Please indicate which of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle) is affected.

___Alcoholism

___Heart Disease

___Depression/Suicide

___Asthma/COPD

___High Cholesterol

___Stroke

___High Blood Pressure

___Diabetes

___Bleeding or Clotting

___Genetic Disorders

___Other

___Cancer: type ____

Signature____