

Health Concepts Thermography Imaging Patient Information Sheet

Name_____ Birth Date_____

Address_____

City_____ State_____ Zip_____

Phone_____ Email_____

Please list any health history pertaining to female, hormone or breast health:
This information is confidential.

Previous Illnesses:

Previous Surgeries:

Current Health Problems:

Medication_____

Other Treatment_____

Do you want a copy of the report forwarded to your doctor? Yes / No

Doctor's Name_____ Location _____

I verify this information is correct and I understand I am responsible for my bill.

Signed_____ Date_____