Thermography Client Information Sheet

Name:_____

Address:_____

City:_____

State:_____ Zip Code:_____ Today's Date:_____

Email:_____

Phone:_____

Date of Birth:_____

Age/Gender:_____

Occupation:_____

Primary Care Physician:_____

Referring Physician:_____

Clinical Concerns:

Current Symptoms:

Current Treatment:

Current Medication:

Scans performed by The Longevity Center of WI.
Interpreted by Meditherm/EMI
Leaders in Thermal Imaging Worldwide ... ***we set the standards!***

Hx = HISTORY

Thermogram Hx:
Previous Report #'s:
Results of clinical correlation:

Surgical Hx:

Dental Hx:

General Hx:

Diagnoses:

Female Patient Only -
Ob/Gyn Hx:

Mammogram/Ultrasound Hx:

Family Hx:

This information is confidential.
All information is correct to my knowledge.
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 be 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 discussed in the Report. By signing below, I certify that I have read and understood the statements above and consent to the examination.

Signature _____

Date_____

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