Ohio Infrared Health
Health History Information Sheet

Name: _____ DOB: _____ Age: _____ Sex _____

Address: _____City/State/Zip: _____

Phone: (H) _____ (W) _____ (C) _____

E-Mail: _____Occupation: _____

Would you like us to mail a copy of your Thermography results to your Health Care Provider? Yes No

Health Care Provider's Name & Address: _____

Main Concern or Reason for Today's Visit: _____

Current Symptoms: _____

Current Treatments: _____

Medical History: _____

Surgical History: _____

Current Medications: _____

Have you ever had a Thermogram? If so, When? _____

Previous Thermogram Results (if applicable): _____

Mammogram/Ultrasound History and Results: _____

Ob/Gyn History: _____

Dental History: _____

Family History: _____

Any Skin Lesions or Physical Abnormalities such as Tattoos, Piercings, Scars or Amputations?

_____

Any other information that you would like for us to know?: _____

*All information is confidential and will only be disclosed to the interpreting doctor for the purpose of clinical correlation with the Thermogram. Per your request, we will also mail a copy of your results to your Health Care Provider for continuity of care purposes.