Midwest Medical Thermography

PATIENT INFORMATION SHEET

(This information is confidential)

NAME: _____ DOB: _____AGE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION: _____

Health Concerns:

Illnesses:

Surgeries:

Family History (parents/siblings):

Medication: _____

Other Treatment: _____

Physician: _____

All information is correct to my knowledge.

Signed: _____ Date: _____

For office use only

Scan Type: _____ PT ID: _____ Rpt. #: _____ Location: _____

Referred by: _____ EMI: ___ E-mailed: ___ Call: ___ Mailed: ___ ROF: ___ Keap: ___

Payment: $_____ Cash/CC/Check # _____ Rcpt: Y / N mail/email DH: $_____

Midwest Medical Thermography
and Health Services

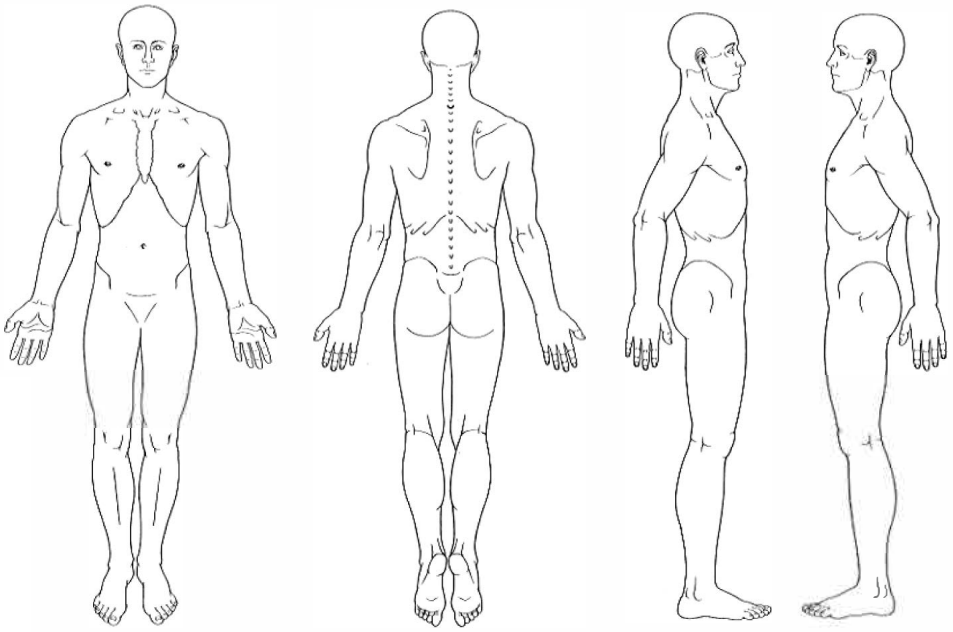
Full Body Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Name: _____ D.O.B: _____

Please Show areas of :

Main Pain	*
Secondary Pain	○
Numbness	////////
Pins and needles	::::::::
Skin lesions / scaring	↗



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries/ Fractures / Surgery

PATIENT DISCLOSURE

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 of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature _____ Date _____

Midwest Medical Thermography
and Health Services

Confidential Men's Health Questionnaire

Name_____ **Date of Birth**_____

1. What is the main reason for today's visit? _____
2. Do you have any other health concerns? _____
3. How would you rate your health? (circle one) Excellent / Good / Fair / Poor
4. How would you rate your energy level? (circle one) Excellent / Good / Fair / Poor
5. How would you rate your strength/endurance? (circle one) Excellent / Good / Fair / Poor
6. Do you experience regular fatigue? Y / N
7. Are you sensitive to cold? Y / N
8. Do you have chronic cold hands and/or feet? Y / N
9. Do you experience regular brain fog? Y / N
10. Have you experienced unexplained weight gain or weight loss? Y / N
11. Have you experienced recent hair loss? Y / N
12. Smoking History
    a. Do you currently smoke? Y / N
        i. If yes, how many packs per day? _____
    b. Have you smoked in the past? Y / N
        i. If yes, when did you quit? _____
        ii. How many packs per day? _____
    c. Are you exposed to second hand smoke? Y / N
13. Are you or have you been exposed to toxic chemicals at work/hobbies? Y / N
14. Do you follow any specific diet? Vegan? Gluten-free? Keto? Other?
15. Do you have any known food sensitivities/allergies? Y / N
16. Do you have any injuries or pain that limit activity? Y / N

17. Do you have any pain or discomfort with any of the following?
    a. Going up and down stairs? Y / N
    b. Prolonged standing? Y / N
    c. Prolonged sitting? Y / N
    d. Prolonged walking? Y / N
    e. Reaching overhead? Y / N

18. Do you have difficulty with walking or keeping your balance? Y / N

19. Have you ever had a colonoscopy? Y / N
    a. If yes, when?
    b. Any abnormalities?

20. Do you have excessive daily sun exposure? Y / N

21. Do you currently have any of the following problems? Please check all that apply to you.

Head/Mouth ☐ Earaches ☐ Ringing in the ears ☐ Sinus problems ☐ Headaches ☐ Dental problems

Cardiovascular ☐ Chest pain ☐ Heart palpitations ☐ Painful breathing ☐ Swelling ☐ Other

Respiratory ☐ Wheezing ☐ Shortness of breath ☐ Chronic cough ☐ Phlegm production ☐ Other

Gastrointestinal ☐ Diarrhea ☐ Abdominal pain ☐ Constipation ☐ Bloody stool ☐ Cramping ☐ Nausea/vomiting ☐ Other

Urinary ☐ Blood in urine ☐ Pain with urination ☐ Urinary frequency ☐ Urgency

Skin ☐ Skin rash ☐ Lesions ☐ Other

Neurological ☐ Dizziness ☐ Seizures ☐ Numbness ☐ Difficulty walking ☐ Headache ☐ Spine injury ☐ Back injury/pain ☐ Radiculopathy ☐ Other

Endocrine ☐ Hot flashes ☐ Abnormal thirst ☐ Increase facial/body hair ☐ Other

Hematologic ☐ Frequent bruising ☐ Enlarged lymph node ☐ Bleeding problems ☐ Lymphedema ☐ Other

PERSONAL MEDICAL HISTORY

☐ Check box if you have no history of significant medical illnesses.

Do you currently have or have you had (in the past) any of the following conditions?

Condition	***Now***	***Past***	***Comments***
Alcohol/Drug Use			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder / Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Breast Lump (benign)			
Cancer - Colon			
Cancer - Other Type			
Cancer - Prostate			
Colon Polyp			
Coronary Artery Disease			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Gallbladder Disease			
Heartburn/GERD			
Gout			
Heart Attack			
Hepatitis – Type A/B/C/Other			
High Blood Pressure			
High Cholesterol			

Condition	*Now*	*Past*	*Comments*
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease / Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Enlargement			
Prostate Nodules			
Seizure / Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid Nodule			
Hyperthyroidism (Overactive)			
Hypothyroidism (Underactive)			
Other (List)			

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