Greenpoint thermography

GENERAL HISTORY FORM

Date: _____

Name: _____ Date of Birth/Age: _____

Address: _____

Phone: _____ Email: _____

Sex: _____ Race: _____ Occupation: _____

Source of Referral: _____

Chief Complaint & History of Present Illness: (Briefly describe your primary complaints or symptoms. For example: persistent cough, painful joints, headache, sinus congestion, etc. Describe when it started, what makes it better or worse, current treatments, etc.)

_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History (include dates if possible)

General State of Health:_____

Past Illnesses: _____
_____
_____
_____
_____

Surgical History: _____
_____
_____
_____
_____

OB/GYN History: _____
_____
_____
_____

Allergies: _____
_____

Current Medications & Supplements (including hormones): _____
_____
_____
_____
_____

Have you had any studies/tests as a result of findings on your last thermogram?
_____
_____
_____
_____

Habits: (How long? How frequently? How much?)
Coffee: _____
Tobacco: _____
Alcohol: _____
Other drugs: _____

Family History: (If living, age and state of health; if deceased, age and cause of death)

Mother: _____
Father: _____
Siblings: _____
_____
_____
Spouse: _____
Children: _____
_____
_____

R or **L** **Handed?** (Circle one)

Other Pertinent Information: (anything else we should know)
_____
_____
_____
Surface Abnormalities: (scars, moles, piercings, tattoos)_____
_____
_____

Signature: _____ Date: _____