

Lighthouse Health and Thermography

[www.lighthousehealthandthermography.com](http://www.lighthousehealthandthermography.com)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Thermography Health history | | | | | | | | | | |
| All questions contained in this questionnaire are strictly confidential  and will become part of your medical record. | | | | | | | | | | |
| Name (Last, First, M.I.): | |  | | | 🞎 M 🞎 F | | DOB: | **Age:** | | |
| **Address:** | | | | **City/State/Zip** | | | | | | |
| **Phone: (home)** | | | | **(cell)** | | | | | | |
| **E-Mail Address:** | | | | | | | | | | |
| **Site Location:** | | |  | | | | | | |  |
| How did you find us? Health Practitioner Referral? Personal Referral? Website? Brochure? Social Media? | | | | | | | | |  | |
| Contact in Case of Emergency: (name and phone number) | | | | | | | | | | |
| Occupation: | | | | | | | | | | |
|  | | | | | | | | | | |
| Dental Work | | | | | | | | | | |
| Fillings: Composite (white)/Amalgam (silver) | | | | | | | | | | |
| Crowns: | | | | | | | | | | |
| Wisdom Teeth: | | | | | | | | | | |
| Root Canals: | | | | | | | | | | |
| Implants: | | | | | | | | | | |
| Periodontal Disease/Gum Issues: | | | | | | | | | | |
| Any other trauma, surgery, or issues in the mouth/jaw? | | | | | | | | | | |
|  | | | | | | | | | | |
| PERSONAL HEALTH HISTORY | | | | | | | | | | |
|  | | | | | | | | | | |
| Concerns Today? **Symptoms/Onset?** | |  | | | | | | | | |
| List any allergies/illnesses/diagnoses (arthritis, nerve damage, chronic pain, headaches, etc.): | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Surgeries or hospitalizations? | | | | | | | | | | |
| Year | Surgery | | | | | Notes | | | | |
|  |  | | | | |  | | | | |
|  |  | | | | |  | | | | |

|  |  |  |
| --- | --- | --- |
| Other hospitalizations or injuries? | | |
| Year | Reason | Outcome |
|  |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| List your prescribed drugs and over-the-counter drugs, such as vitamins, inhalers, birth control, etc.: | | |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Scars/Tattoos/Skin Abnormalities/Removals (tags, moles, warts, cancer, etc.) or known burns or frostbitten areas? | | |
|  |  | |
| |  |  |  | | --- | --- | --- | | Direct Contact EMF Exposure Yes No | | | | Do you wear an electronic band on your wrist? i.e. “Fitbit” or an “Apple Watch” |  |  | | Do you keep a cellphone or other electronic device on your body…i.e. phone in your bra or clothing pocket |  |  | | Do you wear wireless headphones or have WI FI in your car? |  |  |   *To the best of my knowledge, all information is correct. I understand that a certified clinical thermographer/s will take the thermographic images as part of this screening process after which a radiologist will provide findings. I understand that thermography and mammography are different screening tools and our business does not claim that one replaces the other.*   |  | | --- | | Signature: Date: | | If you’d like to stay connected to current information, classes, & specials, check out our website or follow our social media site to stay updated. | | | |
| fOR OFFICE USE | | |
| **ADDITIONAL NOTES:**  **DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **SCAN TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PATIENT ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **REPORT REFERENCE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NEXT APPOINTMENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **REPORT SENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **PAYMENT TYPE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **CLINICAL THERMOGRAPHER\_\_\_\_\_\_\_\_\_\_\_** | | |