Date: ID: Age/Gender: Occupation:
Primary Care Physician: Referring Physician:

Clinical Concerns:

Current Symptoms:

Current Treatment:

Current Medication:

Thermogram Hx:

Previous Report #'s:
Results of clinical correlation:

Surgical Hx:

Dental Hx:

General Hx:

Diagnoses:

Skin Lesions or Physical Abnormalities:

Female Patient Only
Ob/Gyn Hx:

Mammogram/Ultrasound Hx:

Family Hx:

Notes: