Patient Information Sheet.

Name ..... D.O.B. .....

Address .....

Phone (H) ..... (W) .....

Occupation .....

Previous Illnesses.

Previous Surgery.

Current Health Problems.

Medication. .....

Other Treatment. .....

Current Doctor. .....

Do you want a copy of the thermogram report forwarded to your doctor ?
Yes..... No .....

This information is confidential.
All information is correct to my Knowledge.

Signed ..... Date .....