AUBURN THERMOGRAPHY
INFRARED IMAGING CENTER
6000 Fairway Drive, Suite 1
Rocklin, CA 95677

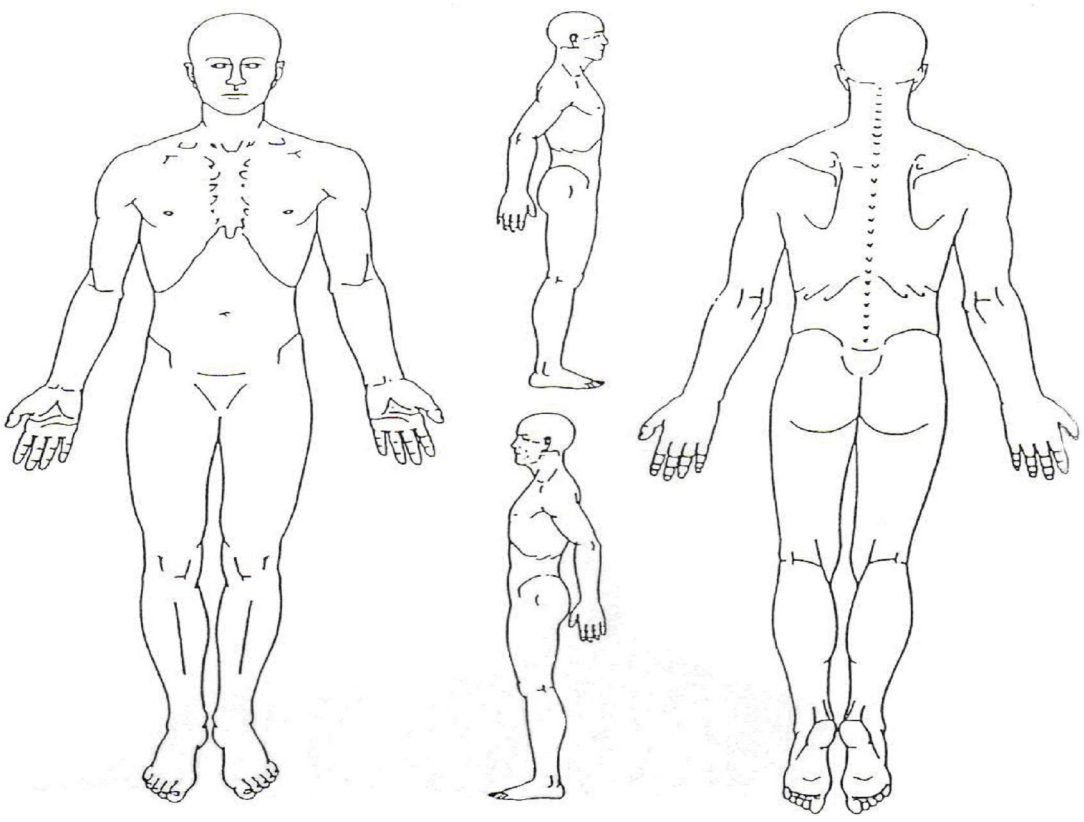
Health History

Patient's Name: _____ **Date:** _____
Address: _____ **City:** _____
State/Province: _____ **Zip/Postal Code:** _____
Date of Birth: _____ **Age:** _____ **Gender:** _____ ❒ **R** ❒ **L** **Handed**
Phone #: _____ **Email:** _____

Please mark the area and type of pain on the drawing using the following code:

N ï Numbness
P ï Pain
T ï Tingling
A ï Ache
S ï Soreness
ST ï Stiffness

Please mark all scars using the following: ++++



Right **Left** **Left** **Left** **Right**

What are your current complaints? _____

_____

_____

_____

_____

_____

_____

Have you ever been diagnosed with cancer? ❒ Y ❒ N

Date: _____ Type: _____

Do you have any current diagnoses / diseases / conditions? ❒ Y ❒ N
List diagnoses / diseases / conditions: _____

_____

Have you had any surgeries? ❒ Y ❒ N
List surgeries and dates: _____

_____

Have you had any broken bones / fractures? ❒ Y ❒ N
List bones broken / fractures and dates: _____

_____

Have you had any dental work in the past 2 months? ❒ Y ❒ N
Type of work and dates (give location ï ex. rear upper molars): _____

Have you had a flu, cold, or respiratory illness in the past month? ❒ Y ❒ N

Do you suffer from any condition other than that which has been listed previously? ❒ Y ❒ N
If yes, what is it? _____

I have completed this 2-page form to the best of my ability.

Signature: _____ Date: _____

Office Use Only: Tech: _____ Re-Exam: ❒ Y ❒ N

Pt T: _____ F Rm T: _____ C

Image Series: ❒ Upper Body ❒ Lower Body ❒ Full Body ❒ Maxillofacial ❒ ROI