



Head & Thyroid Thermography Patient Intake Form

Personal Information:

Today's date: _____

Name: _____ Sex: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone: _____ Alternate Phone: _____ Marital Status: _____

E-Mail Address: _____

Emergency Contact Person: _____ Relationship: _____ Phone #: _____

Family History: Please list and describe family history of thyroid problems: __________
_____**Operations & Procedures:**

- Tonsillectomy _____ Date: _____
- Tubes in Ear _____ Date: _____
- Sinus _____ Date: _____
- Thyroid _____ Date: _____
- Dental Extractions (Which Tooth): _____ Date: _____
- Other: _____ Date: _____

Pain, Inflammation, Concerns, Complains: Please describeDental (Include all dental work): _____

Jaw: _____

Gums: _____

Do you experience any of the following?

- Fatigue / Sluggishness
- Weight Gain
- Weight Loss
- Increased Sensitivity to Cold
- Increased Sensitivity to Heat
- Constipation
- Muscle aches, tenderness and stiffness
- Pain, stiffness or swelling in you joints
- Depression
- Pale, dry skin
- Itchy Skin
- Puffy face
- Hoarse voice
- Elevated blood cholesterol level
- Muscle weakness
- Heavier than normal menstrual periods
- Neck Modules

Thyroid Medication: List _____
_____**Blood Tests for Thyroid:**

Type of Test: _____ Date Done: _____

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Type of Test: _____ Date Done: _____