

New England Clinical Thermography Incorporated
Patient Information Sheet

Last Name: _____ First: _____ MI: _____
DOB _____ E-mail _____

Previous Illnesses: _____

Current Health
Problems: _____

Medications: _____

Other Treatment: _____

Current Doctor: _____
Address: _____
Phone: _____

How did you learn of imaging at this location?

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

Signed: _____

Date: _____