bloomington wellness center

Thermography
Health History

952.881.2800 office
5143 w 98th street
bloomington, mn 55437
wellbloomington.com

Men's Full Body Screening

Date:___/___/201___

Patient Name: _____

Head & Neck

	Yes	No
1. Do you ***suffer*** with headaches?	o	o
If yes: o less than or equal to once per month o more than once per month		
2. Do you have allergies?	o	o
If yes: Food _____ Environmental_____		
3. Do you have TMJ or does your jaw click?	o	o
4. Do you currently have a cold?	o	o
5. Are you being treated for a thyroid disorder?	o	o
If yes: Type_____		
6. Do you have neck pain?	o	o
7. Do you have upper back pain?	o	o
8. Do you have a history of carotid artery disease?	o	o
9. Do you have a family history of stroke?	o	o
10. Do you currently ***suffer*** with sinus problems?	o	o

Do you have other concerns or information related to ***Head & Neck***? If so, please list below:

_____

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	o	o
Lung disease?	o	o
Upper spine disorders?	o	o
2. Do you ***suffer*** with upper back pain?	o	o
3. Do you ***suffer*** with chest pain?	o	o
4. Have you ever had surgery to your:		
Heart?	o	o
Mid to upper back?	o	o
Lungs?	o	o
5. Do you have asthma or shortness of breath?	o	o
6. Do you currently smoke?	o	o
7. Have you smoked in the past 5 years?	o	o

Do you have other concerns or information related to ***Chest, Heart & Lungs***? If so, please list below:

_____

Patient Name: _____

Abdomen & Lower Back

	Yes	No
1. Do you ***suffer*** with acid reflux?	o	o

2. Do you ***suffer*** pain in the:

	Yes	No		Yes	No
Stomach?	o	o	Abdomen?	o	o
Below R Breast?	o	o	Lower Back?	o	o
Below L Breast?	o	o	Pelvic Region?	o	o

Have you had surgery or disease in the:

Stomach?	o	o	Intestines ?	o	o
Spleen(Upper Left)?	o	o	Abdomen?	o	o
Liver(Upper Right)?	o	o	Lower Back?	o	o
Kidneys?	o	o	Pelvic Region?	o	o

Have you consumed ANY alcohol in the past 24 hours?	o	o

Do you have other concerns or information related to ***Abdomen & Lower Back***? If so, please list below:

_____

Legs & Feet

1. Do you ***suffer*** pain in the:

	Yes	No	Rt or Lt	
Leg	o	o	o	o
Sciatica	o	o	o	o
Buttocks/Hip	o	o	o	o
Knees	o	o	o	o
Feet	o	o	o	o
Ankles	o	o	o	o

2. Have you had surgery to the:

Leg	o	o	o	o
Sciatica	o	o	o	o
Buttocks/Hip	o	o	o	o
Knees	o	o	o	o
Feet	o	o	o	o
Ankles	o	o	o	o

Do you have other concerns or information related to ***Legs and Feet***? If so, please list below:

_____

Patient Name: _____

Arms & Hands

		Yes	*No*	*Rt or Lt*	
1. Do you suffer with pain in the:	Shoulder	o	o	o	o
	Elbow	o	o	o	o
	Arm	o	o	o	o
	Hands	o	o	o	o
2. Have you had surgery to:	Shoulder	o	o	o	o
	Elbow	o	o	o	o
	Arm	o	o	o	o
	Hands	o	o	o	o

3. Have you ever been diagnosed with diabetes? o o

Do you have other concerns or information related to ***Arms and Hands***? If so, please list below:

_____

Do you have other relevant concerns or information you wish to share? If so, please list below:

_____

_____

Thermography Procedure:

-You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings.
-Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose disease.
-Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other examination.

Patient Disclosure:

-I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment.
-I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis.
-I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.
-By signing below, I certify that I have read and understand the statement above and consent to the examination.

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist at Physician's Insight, and any other practitioner that you specify.

Acceptance:

Signature: _____ Date: _____