



Office Use Only!	
Filed	_____
Mailed	_____
Payment	_____

Annual Report
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Are There Any Changes Since the Last Visit? Be very specific about breast health.

Name \_\_\_\_\_ D.O. B. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ (H) \_\_\_\_\_ (W)

E-mail \_\_\_\_\_ Occupation \_\_\_\_\_

Previous Surgeries

Current Health Problems – Any breast changes or updates?

Medications

Other Treatments

Current Doctor

Signed \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_

All Clinical Thermographers are trained and certified by the ACCT