



Office Use Only!	
Filed	_____
Mailed	_____
Payment	_____

Three Month Baseline Report

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