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