





List any treatments you have had: \_\_\_\_\_

List any surgeries, especially related to your concern: \_\_\_\_\_

List any other medical conditions: \_\_\_\_\_

List any medications you are taking: \_\_\_\_\_

List and describe the locations of any rash or markings on your body: \_\_\_\_\_

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**Release for testing Procedure**

Thermal Imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging examinations.

I have complied with the pre-examination instructions for proper thermal imaging.

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please do not write in this section

Digital Exam: \_\_\_\_\_ D Re-Exam: \_\_\_\_\_ Tech: \_\_\_\_\_ Patient T: \_\_\_\_\_ F

Laboratory  
Temperature  
\_\_\_\_\_ C