WHOLISTIC
Thermography

Patient Review of Body Systems

Name: _____ Date: _____

CONSTITUTIONAL

- ☐ Fevers/Chills/Sweats
- ☐ Unexplained Weight Loss/Gain
- ☐ Fatigue/Weakness
- ☐ Excessive Thirst or Urination

MUSCULOSKELETAL

- ☐ Muscle Pain
- ☐ Joint Pain

EARS/NOSE/THROAT

- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Hay Fever
- ☐ Allergies

CARDIOVASCULAR

- ☐ Chest Pain/Discomfort
- ☐ Leg Pain with Exercise
- ☐ Palpitations

DENTAL

- ☐ Fillings
- ☐ Extractions (wisdom teeth)
- ☐ Root Canal
- ☐ Crowns
- ☐ Partial/Dentures
- ☐ Gum Disease

RESPIRATORY

- ☐ Cough
- ☐ Wheeze
- ☐ Difficulty Breathing
- ☐ Frequent colds/flu
- ☐ Covid-19

GASTROINTESTINAL

- ☐ Heartburn
- ☐ Reflux
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Large Bowel Dysfunction
- ☐ Abdominal Pain/Discomfort

SKIN

- ☐ Rash or Moles
- ☐ Lesions

NEUROLOGICAL

- ☐ Numbness/Tingling
- ☐ Headaches

ORGAN DYSFUNCTION

_____

_____

BLOOD/LYMPHATIC

- ☐ Unexplained Lumps
- ☐ Easy Bruising
- ☐ Blood Clotting

OTHER (SPECIFY)

_____

_____

WHOLISTIC Thermography

Patient Review of Body Systems

GENERAL MEDICAL HISTORY: PAST AND CURRENT MEDICAL ISSUES

- ☐ Heart Disease: (Specify) _____ _____
- ☐ Asthma or Lung Disease
- ☐ Accidents
- ☐ High Blood Pressure
- ☐ Thyriod Problems
- ☐ Chemical Exposure
- ☐ Injuries
- ☐ Other_____
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Cancer: (Specify) _____ _____

ADDITIONAL INFO LIKE DATES OF INCIDENTS: _____

_____

FAMILY HISTORY: Please indicate any of these conditions affecting your immediate family members

(M: Mother, F: Father, Grandparents: MGM, MGF, PGM, PGF, S: Siblings, A: Aunts, U: Uncles

- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Stroke
- ☐ Genetic Disorders
- ☐ Asthma ir COPD
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding/Clotting Disorder
- ☐ Dementia/Parkinson's
- ☐ Cancer: (Specify) _____

Signed:_____ Date: _____