Annual Report

Office Use Only!

Filed_____

Emailed_____

Payment_____

Report ID_____

Are there any changes since the last visit? Be very specific about breast health.

Name _____ D.O. B. _____

Address _____

City _____St. _____Zip _____

Phone _____ E-mail _____

Occupation _____

Previous Surgeries

_____

_____

_____

Current Health Problems – Any breast changes or updates?

_____

_____

_____

Medications

_____

_____

_____

Other Treatments

_____

_____

Current Doctor _____

Signed _____ Date _____

Thermographer Name _____

All Clinical Thermographers are trained and certified by the ACCT