Men's Full Body Study

Name_____ Birth Date_____ Today's Date _____

Address_____ City_____ State_____ Zip_____

Phone Number (cellular)_____(work)_____

E-Mail Address_____Referring Physician_____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermographer and any other practitioner that you specify.

Head & Neck

1. Do you suffer with headaches?

If yes, once a month or less____ More than once a month____ No____

2. Do you have any known allergies?

If yes, food____ Environmental_____ No____

3. Do you have TMJ or does your jaw click?

Yes____ No____

4. Do you currently have a cold?

Yes____ No____

5. Are you being treated for a thyroid disorder?

If yes, what type? _____ No____

6. Do you have neck pain?

Yes____ No____

7. Do you have upper back pain?

Yes____ No____

8. Do you have a known history of carotid artery disease?

Yes____ No____

9. Do you have a family history of stroke?
Yes____ No____

10. Do you currently suffer with sinus problems?
Yes____ No____

11. Do you have a history of dental problems?

If yes, Root canals ____ Gum disease ____ Implants ____ Non-replaced extractions ____

Dentures ____ No____

12. Have you had dental cleaning in the past 7 days?
Yes____ No____

13. Have you been diagnosed with elevated cholesterol?
Yes____ No____

Chest, Heart & Lungs

1. Have you ever been diagnosed with:
Heart disease ____ Lung disease ____ Upper spine disorders____ No___

2. Do you suffer with upper back pain?
Yes____ No____

3. Do you suffer with chest pain?
Yes____ No____

4. Have you ever been diagnosed with scoliosis?
Yes____ No____

5. Have you ever had surgery to your:
Heart____ Lungs____ Mid to upper back____ No___

6. Do you have asthma or shortness of breath?
Yes____ No____

7. Do you currently smoke?
Yes____ No____

8. Have you ever smoked?
If yes, for how long_____ Packs/Day____ No___

9. Do you suffer with shoulder pain?
If yes, Left____ Right____ No____

Abdomen & Lower Back

1. Do you suffer with acid reflux or other digestive problems?
Yes____ No____

2. Do you suffer with pain in the:
Stomach____ Abdomen____

Below left breast____ Lower Back____

Below right breast____ Pelvic Region____ No____

3. Have you ever had surgery or disease in the:
Stomach____ Intestines____

Spleen (Upper Left) ____ Abdomen____

Liver (Upper Right) ____ Lower back____

Kidneys____ Pelvic region____ No____

4. Have you consumed alcohol in the past 24 hours?
Yes____ No____

Legs & Feet

1. Do you suffer with pain in the: (Check only if "yes")

Leg Lt___ RT___ Knees LT___ RT___

Sciatica LT___ RT___ Feet LT___ RT___

Buttocks/Hip LT___ RT___ Ankles LT___ RT___

2. Have you ever had surgery to: (Check only if "yes")

Leg LT___ RT___ Knees LT___ RT___

Sciatica LT___ RT___ Feet LT___ RT___

Buttocks/Hip LT___ RT___ Ankles LT___ RT___

Arms & Hands

1. Do you suffer with pain in the: (Check only if "yes")

Shoulder LT___ RT___ Arm LT___ RT___

Elbow LT___ RT___ Hands LT___ RT___

2. Have you had surgery to: (Check only if "yes")

Shoulder LT___ RT___ Arm LT___ RT___

Elbow LT___ RT___ Hands LT___ RT___

Areas of Pain

Mark on the graph to indicate any areas of pain, surgery, or injury: