

**Patient Information Sheet**

Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate: \_\_\_\_\_ Email: \_\_\_\_\_

Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

This information is confidential. Please list any health history pertaining to female, hormone or breast health:

Previous Illnesses:

Previous Surgeries:

Current Health Problems:

If you are having any other regions scanned please describe primary pain, secondary pain etc. Please note symptoms such as numbness, tingling, aching or stabbing etc:

Medication \_\_\_\_\_

Other Treatment \_\_\_\_\_

Do you want a copy of the report forwarded to your doctor? Yes / No

Doctor's Name \_\_\_\_\_ Location \_\_\_\_\_

(\$5.00 processing fee. \$20 rush fee)

I verify this information is correct and I understand I am responsible for my bill.

Signed \_\_\_\_\_ Date \_\_\_\_\_