Lighthouse
HEALTH & THERMOGRAPHY

# THERMOGRAPHY HEALTH HISTORY

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|---|---|---|---|
| **Name** *(Last, First, M.I.):* ☐ M ☐ F | | **DOB:** | **Age:** |
| **Address:** | **City/State/Zip** | | |
| **Phone:** **(home)** | | | **(cell)** |
| **E-Mail Address:** | | | |
| **Occupation:** | | | |
| **Site Location:** | | | |
| **How did you find us? Health Practitioner Referral? Personal Referral? Website? Brochure? Social Media?** | | | |

| **CURRENT CONCERNS** |
|---|
| **Concerns Today?** |
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| **Symptoms/Onset?** |
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**THERMOGRAPHY HISTORY—CIRCLE ONE: 1ST SCAN EVER 1ST SCAN WITH LIGHTHOUSE UNSURE**

**HEALTH CHALLENGES--Circle any issues that apply:**

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|---|---|---|---|---|---|---|---|---|
| Sinus | Heart | Circulation | Chronic Pain | Digestive | Diabetes | Arthritis | Gallbladder | Thyroid: Hyper or Hypo |
| Cholesterol | Kidney | Adrenal | Poor Sleep | Constipation | Cancer | Pins/Needles | Liver | Spine |
| Lyme's | Acid Reflux | Fatigue | Headaches | Diarrhea | Methylation | Brain Fog | Parkinsons | Allergies |
| Endometriosis | PCOS | Fatty Liver | Hormone Imbalance | Colon | Ehlers-Danlos | Urinary Tract Infections | Celiac | Diverticulitis |
| Lupus | Tinnitus | Ulcers | Dysphagia | POTS | Swollen Lymph Nodes | Skin Rashes | Crohn's | Repeatedly Ill |

**Additional:**

**SURGERIES & HOSPITALIZATIONS**

| Year | Surgery | Notes |
|---|---|---|
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| OTHER INJURIES OR TREATMENTS (Concussions, car accidents, broken bones, etc.) | | |
|---|---|---|
| Year | Reason | Outcome |
| | | |
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| WELLNESS PRACTICES—Circle all that apply | | | | | |
|---|---|---|---|---|---|
| **Massage** | **Sauna** | **Rebounding** | **Prayer/Meditation** | **Movement/Exercise** | **Clean Eating or Specific Diet** |
| **Chiropractic** | **Red Light** | **Dry Brushing** | **Emotion/Body Code** | **Counseling** | |
| **Acupuncture** | **Cold Plunge** | **Chi Machine** | **Sound Therapy** | **Lymphatic work** | |
| **Cranial Sacral** | **IV Infusions** | **Previous or current practitioners (MD, Chiropractor, Naturopath, NRT, Neurologist, Specialist, etc.):** | | | |
| **PEMF Mat** | **Foot Detox** | | | | |
| **Grounding** | **Fasting** | | | | |
| **EMF Mitigation** | **Vibe Plate** | | | | |
| **Breath Work** | **Energy Spa** | | | | |

| DENTAL WORK |
|---|
| **Fillings:** **Composite (white)/Amalgam (silver)** |
| **Crowns:** |
| **Wisdom Teeth:** ☐ **All 4 Extracted** ☐ **All 4 Intact** ☐ **Other:** |
| **Root Canaled Teeth:** |
| **Implants:** |
| **Periodontal Disease/Gum Issues:** |
| **Any other trauma, surgery, or issues in the mouth/jaw? TMJ? Grinding/Clenching?** |
| **Sinus issues:** |

| HEALTH HISTORY CONTINUED |
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| **Family History (Cancer, Heart Disease, Diabetes, etc.):** |
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| **Skin Abnormalities (Scars, tattoos, mole/cancer removals, warts, frost bite, etc.):** |
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| **Have you had a flu shot in the last 4 weeks? Yes No** |
| **Have you had any of the COVID vaccines? (Lymphatic function can be altered) Yes No** |
| **If yes, which one? Year/s: Arm:** |

| HORMONES |
|---|
| **FEMALES ONLY: Have you ever had or do you currently have an IUD? Yes No Dates: Type:** |
| **If yes, does this device release hormones? Yes No** |
| |
| **Have you ever had a hormone panel completed? Yes No** |
| **Year? Results?** |
| **Are you currently or have you previously been on hormone replacement therapy? Yes No** |
| **If yes, were they bioidentical? Yes No** |
| **How was/is it administered? Oral Transdermal Injectable Vaginal Rectal** |

| PRESCRIBED DRUGS | | |
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| SUPPLEMENTATION |
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***Do you get regular, uninhibited sun exposure OR do you supplement with Vitamin D? Yes No**

| DIRECT CONTACT EMF EXPOSURE | Yes | No |
|---|---|---|
| Do you wear an electronic band on your wrist? i.e. Fitbit, Apple Watch | | |
| Do you keep a cellphone or other electronic device on your body? i.e. phone in your bra or clothing pocket | | |
| Do you wear a wireless headset or ear buds or us a wireless mouse daily? | | |

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| ADDITIONAL |
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| **Anything else you would like us to know?** |
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| FOR OFFICE USE ONLY | |
|---|---|
| **DATE**_____<br>**SCAN TYPE**_____<br>**PATIENT ID#**_____<br>**REPORT REFERENCE #**_____<br>**NEXT APPOINTMENT**_____<br>**REPORT SENT**_____<br>**PAYMENT TYPE**_____<br>**CLINICAL THERMOGRAPHER**_____ | **ADDITIONAL NOTES:** |