Name: _____ **Birthdate:** _____

Address: _____ **City** _____ **Zip** _____

Email: _____ **Phone:** _____ **Doctor:** _____

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

Breast Thermography Confidential Questionnaire

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
5. Have you had any breast cosmetic surgery or implants?	☐	☐
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you suffered with cancer of the womb?	☐	☐
11. Have you had pharmaceutical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

14. How many mammograms have you had in total? _____

15. What was your age when you had your first mammogram? _____

16. How many births have you had? _____ **Your age at birth of first child:** _____

17. Did your periods start before the age of 12? _____ **Or finish after the age of 50?** _____

18. Do you smoke? Yes: ☐ **Never:** ☐ **Not in last 12 months:** ☐ **Not in last 5 years:** ☐

Have you recently had any of these breast symptoms:	**Right Breast.**	**Left Breast**
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature …….. Today's date _____

Extended Breast Questionnaire

Patient Name: _____ Date:_____

Diagnosed with breast cancer:

Cancer type: Metastatic___ Local___ Lymph node involvement___

When diagnosed: Month_____ Year_____

Where (left breast): UO____ UI____ LO____ LI____Nipple____

Where (right breast): UO____ UI____ LO____ LI____Nipple____

Treatment: Surgery____ Chemo____ Radiation____Other____ None____

Diagnosed with other breast disease:

Disease type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other ____
(please report other types of disease in the history)

Breast biopsies or surgery:

Where (left breast): UO____ UI____ LO____ LI____Nipple____

Where (right breast): UO____ UI____ LO____ LI____Nipple____

Full Body Study Questionnaire

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

Name: **Birthdate**

Address: _____

City **Zip**

Phone: _____ **Your Doctor:**

Please Show areas of :

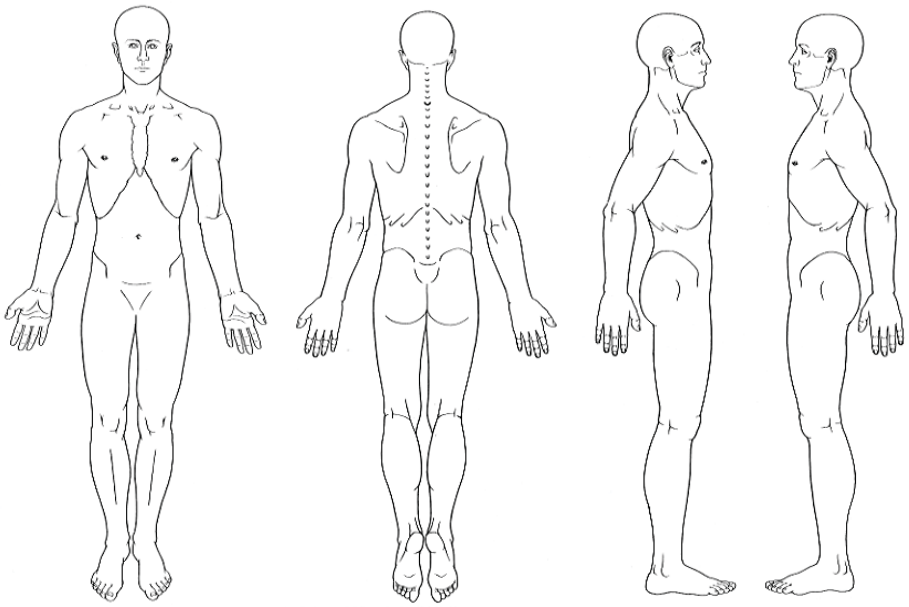
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries / Fractures / Surgery

PATIENT DISCLOSURE

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By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ……..

Upper Body Study Questionnaire

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

Name: _____ **D.O.B:** _____

Address: _____

Phone: _____ **Your Doctor:** _____

Please Show areas of :

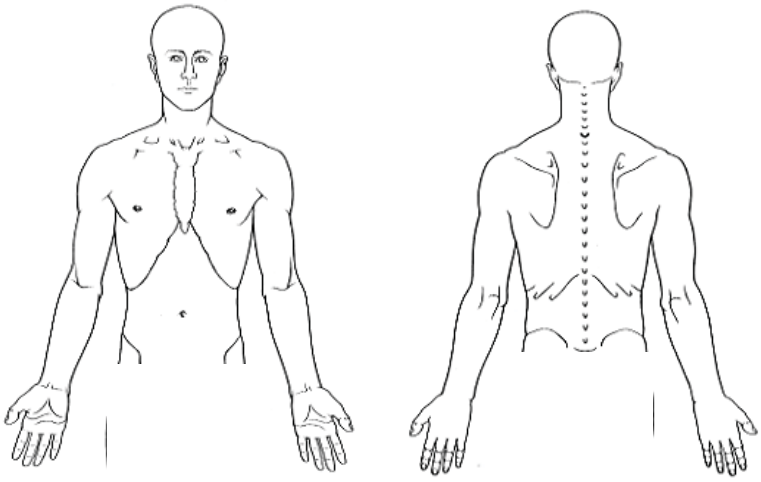
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring ↗



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries / Fractures / Surgery

PATIENT DISCLOSURE

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By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ……..

Lower Body Study Questionnaire

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

Name: _____ **D.O.B:** _____

Address: _____

Phone: _____ **Your Doctor:** _____

Please Show areas of :

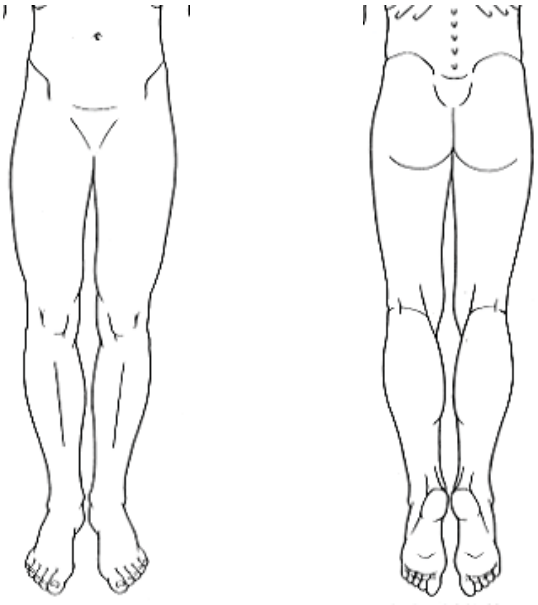
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring ↗



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries / Fractures / Surgery

PATIENT DISCLOSURE

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By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ……..

Region of Interest / Special Study Questionnaire

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

Name: _____ **D.O.B:**

Address:

Phone: **Your Doctor:**

Please Show areas of :

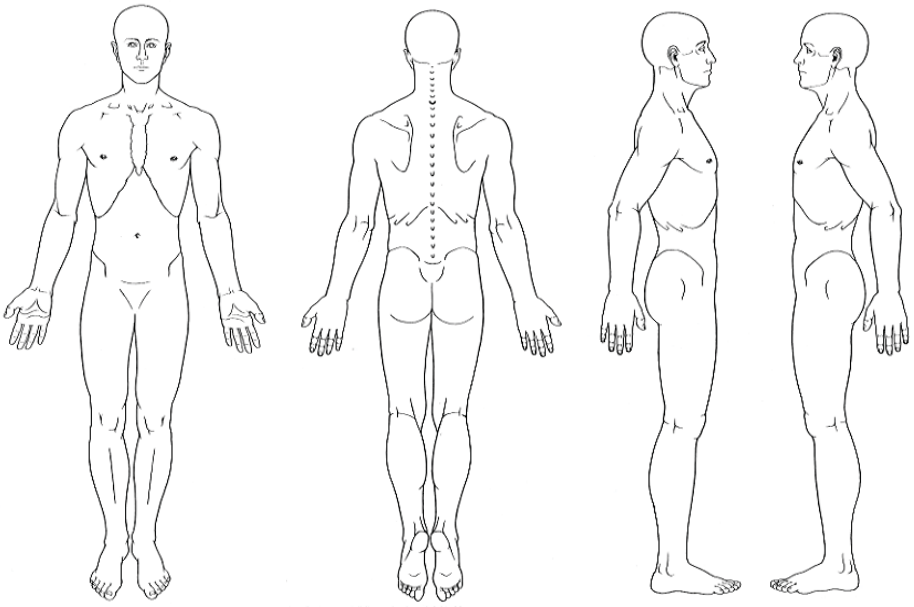
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

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By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ……..

Patient Information Sheet.

Name ……. D.O.B. …….

Address ……..

Phone (H) ……. (W) ……..

Occupation ……..

Previous Illnesses.

Previous Surgery.

Current Health Problems.

Medication. …….

Other Treatment. …….

Current Doctor. …….

Do you want a copy of the thermogram report forwarded to your doctor ?
Yes…… No ……..

This information is confidential.
All information is correct to my Knowledge.

Signed …….. Date ……..