Confidential Questionnaire

Chest and Breast Study

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cellular)_____(work)_____

Email_____ Physician_____

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.

Chest and Upper Back

	Yes	No
1. Have you been diagnosed with:		
Heart disease? _____	___	___
Lung disease? _____	___	___
Upper spine disorders? _____	___	___
2. Do you suffer with upper back pain?	___	___
3. Do you suffer with chest pain?	___	___
4. Have you been diagnosed with scoliosis?	___	___
5. Have you ever had surgery related to your:		
Heart? _____	___	___
Lungs?_____	___	___
Mid to upper back? _____	___	___
6. Do you have asthma or shortness of breath?	___	___
7. Do you currently smoke?	___	___
8. Have you smoked in the past 5 years?	___	___
9. Do you suffer with shoulder pain?	___	___

Do you have any special concerns or additional details related to the information above?

Breast

Is there a specific reason or concern for this breast exam?

	Yes	No
1. Have you recently had any of these breast symptoms? (Mark only if "yes")	___	___

	LT	RT
Pain/Tenderness	___	___
Lumps	___	___
Change in breast size	___	___
Areas of skin changes thickening or dimpling	___	___
Excretions or changes of the nipple	___	___

2. Are any of the above symptoms cycle related? ___ ___

3. Are you still having your periods? If yes: Date of last period _____ ___ ___

4. Have you had a surgical hysterectomy? ___ ___

   If yes, date_____ Complete __ Partial ___

   Reason for hysterectomy?

   ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? ___ ___

   If yes, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter

   Age diagnosed _____ Result of Treatment_____

6. Have you ever been diagnosed with breast cancer? ___ ___

   If yes, date: _Month _____ Year _____

   Cancer type ○ Local ○ Metastatic ○ Lymph node involvement

   Left breast ○ Inner ○ Outer ○ Nipple

   Right breast ○ Inner ○ Outer ○ Nipple

   Treatment ○ Surgery ○ Chemo ○ Radiation ○ None

   If surgery; ○ Mastectomy ○ Lumpectomy

7. Have you ever been diagnosed with any other breast disease? ___ ___

   If yes: Cysts/fibrocystic ___ Fibro Adenoma ___

   Mastitis/inflammatory breast disease ___

8. Have you had any cosmetic breast surgery or implants? ___ ___

   If yes, date_____ ○ Silicone ○ Saline

   Experience: ○ Problems ○ No problems

9. Have you ever had any biopsies or any other surgeries to your breasts ___ ___

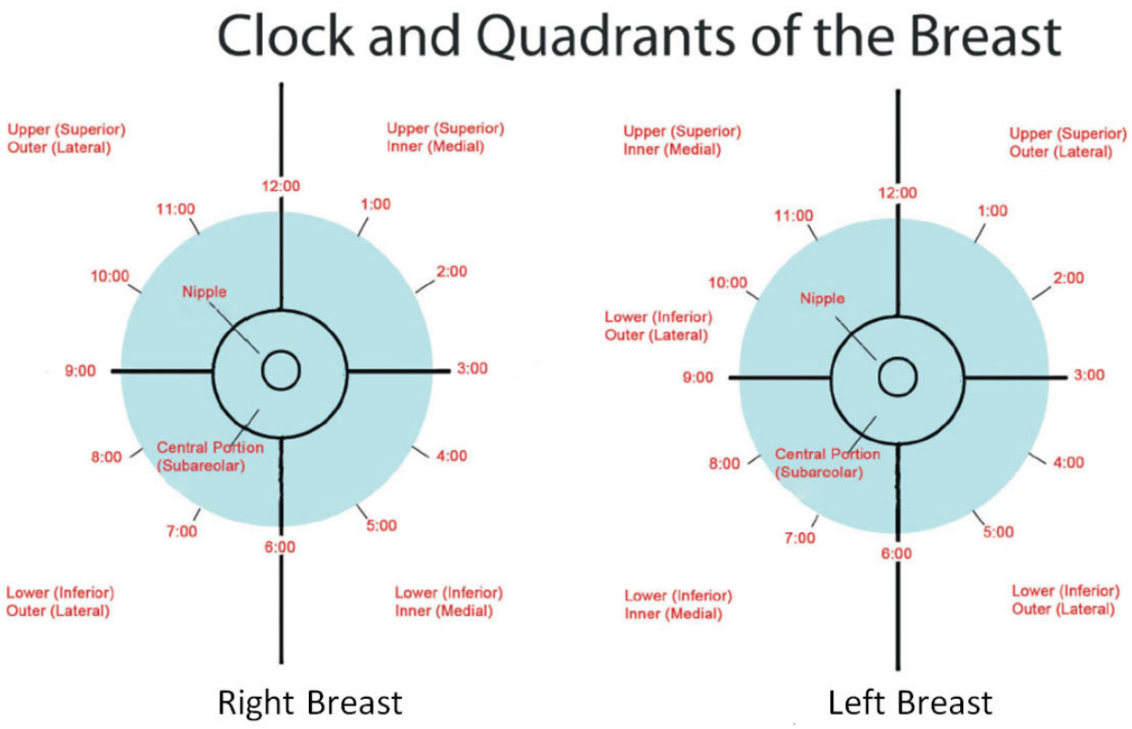
   If yes, date_____

   Left breast ○ Inner ○ Outer ○ Nipple

   Right breast ○ Inner ○ Outer ○ Nipple

   Results ○ Negative ○ Positive ○ Calcifications

Mark on the following graph to indicate location of pain, surgery or lumps:



	Yes	No
10. Have you ever taken contraceptive pills for more than one year? If yes, ○ Currently ○ Less than 5 years ○ More than 5 years	___	___
11. Have you had pharmaceutical hormone replacement therapy (HRT)? If yes, ○ Currently ○ Less than 5 years ○ More than 5 years	___	___
12. Do you have an annual physical examination by a doctor?	___	___
13. Do you perform a monthly breast self-exam?	___	___
14. Have you ever smoked?	___	___
15. Have you ever been diagnosed with diabetes?	___	___
16. Total mammograms____		
17. Date of last mammogram _____ Were you re-called?	___	___
18. Your age at your first mammogram?_____		
19. Number of full term pregnancies?_____		
20. Have you had breast ultrasound? If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___	___	___
21. Have you had breast MRI? If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___	___	___

Client Disclosure

Breast thermography is a non-contact, private and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes**. It offers men and women information that no other procedure can provide regarding inflammation.**

Procedure: You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment

Client Disclosure: I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self- evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement.

Client Signature _____ Today's Date_____