# Confidential Questionnaire

## *Women's Full Body*

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

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

Email_____ Physician's Name_____

*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.*

| | Yes | No |
|---|---|---|
| ***Head & Neck*** | | |
| 1. Do you suffer with headaches? | ___ | ___ |
| If yes, once a month or less ___ more than once a month ___ | | |
| 2. Do you have known allergies? Food ____ Environmental___ | ___ | ___ |
| 3. Do you have TMJ or does your jaw click? | ___ | ___ |
| 4. Do you currently have a cold? | ___ | ___ |
| 5. Are you being treated for a thyroid disorder? Type_____ | ___ | ___ |
| 6. Do you have neck pain? | ___ | ___ |
| 7. Do you have upper back pain? | ___ | ___ |
| 8. Do you have a known history of carotid artery disease? | ___ | ___ |
| 9. Do you have a family history of stroke? | ___ | ___ |
| 10. Do you currently suffer with sinus problems? | ___ | ___ |
| 11. Do you have history of dental problems? | ___ | ___ |
| Root canals ____ Gum disease ____ Implants ____ | | |
| Non-replaced extractions ____ Dentures ____ | | |
| 12. Have you had dental cleaning in the past 7 days? | ___ | ___ |
| 13. Have you been diagnosed with elevated cholesterol? | ___ | ___ |

Do you have any special concerns or are there any 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 ___ ___

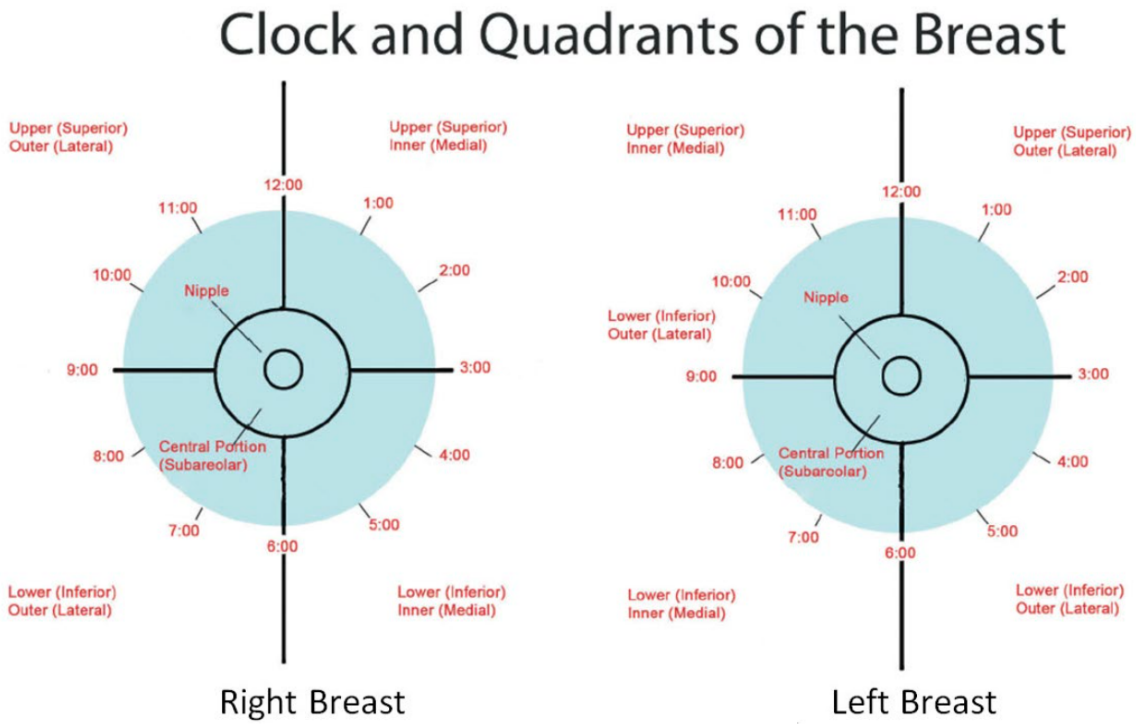
   If yes, date_____

   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?<br>If yes, ○ Currently ○ Less than 5 years ○ More than 5 years | ___ | ___ |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)?<br>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?<br>If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___ | ___ | ___ |
| 21. Have you had breast MRI?<br>If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___ | ___ | ___ |

## *Chest, Heart & Lungs*

| 1. Have you been diagnosed with: | Yes | No |
|---|---|---|
| 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 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? If yes, mark below | ___ | ___ |

## *Abdomen & Lower Back*

| 1. Do you suffer with acid reflux or other digestive problems? Yes___ No___ | 3. Have you had surgery or disease in the: |
|---|---|
| 2. Do you suffer pain in the: | Stomach? Yes___ No___ |
| Stomach? Yes___ No___ | Spleen(Upper Left) ? Yes___ No___ |
| Below R Breast? Yes___ No___ | Liver(Upper Right) ? Yes___ No___ |
| Below L Breast? Yes___ No___ | Kidneys ? Yes___ No___ |
| Abdomen? Yes___ No___ | Intestines ? Yes___ No___ |
| Lower Back? Yes___ No___ | Abdomen ? Yes___ No___ |
| Pelvic Region? Yes___ No___ | Lower Back? Yes___ No___ |
| | Pelvic Region? Yes___ No___ |

4. Have you consumed alcohol in the past 24 hours? Yes___ No___

## *Legs & Feet*

Check only if "Yes"

| 1. Do you suffer pain in the: | 2. Have you had Surgery to: |
|---|---|
| Leg? LT___ RT___ | Leg? LT___ RT___ |
| Sciatica LT___ RT___ | Sciatica? LT___ RT___ |
| Buttocks/Hip? LT___ RT___ | Buttocks/Hip? LT___ RT___ |
| Knees? LT___ RT___ | Knees? LT___ RT___ |
| Ankles? LT___ RT___ | Ankles? LT___ RT___ |

| Feet? LT___ RT___ | Feet? LT___ RT___ |
|---|---|

## *Arms & Hands*

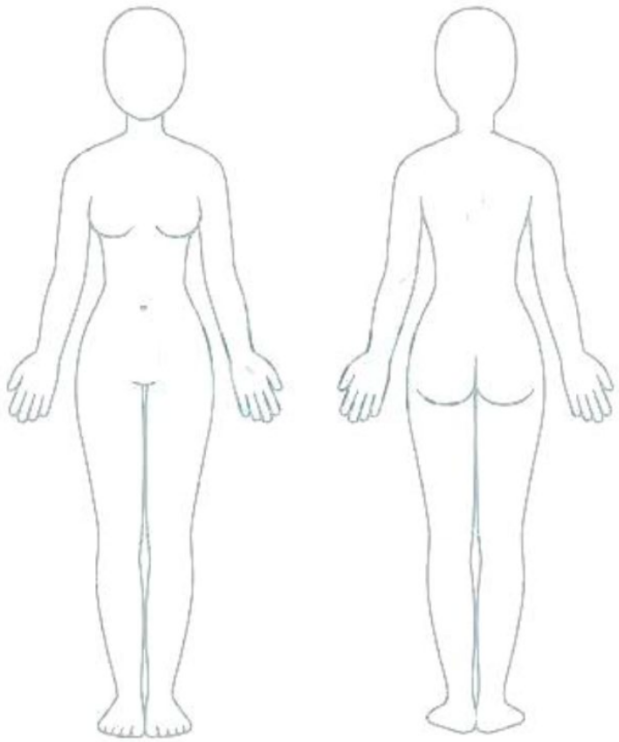
*(Check only if "yes")*

| 1. Do you suffer with pain in the: | LT | RT | 2. Have you had surgery to: | LT | RT |
|---|---|---|---|---|---|
| Shoulder? | ____ | ____ | Shoulder? | ____ | ____ |
| Elbow? | ____ | ____ | Elbow? | ____ | ____ |
| Arm? | ____ | ____ | Arm? | ____ | ____ |
| Hands? | ____ | ____ | Hands? | ____ | ____ |

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

## *Areas of Pain*

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



***Areas of Pain***

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

**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_____