

# Confidential Questionnaire

## *Women's Health Study with Abdomen*

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.*

**Yes No**

### ***Head & Neck***

- |  |       |       |
|--|-------|-------|
| 1. Do you suffer with headaches?<br>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?<br>Root canals _____ Gum disease _____ Implants _____<br>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?

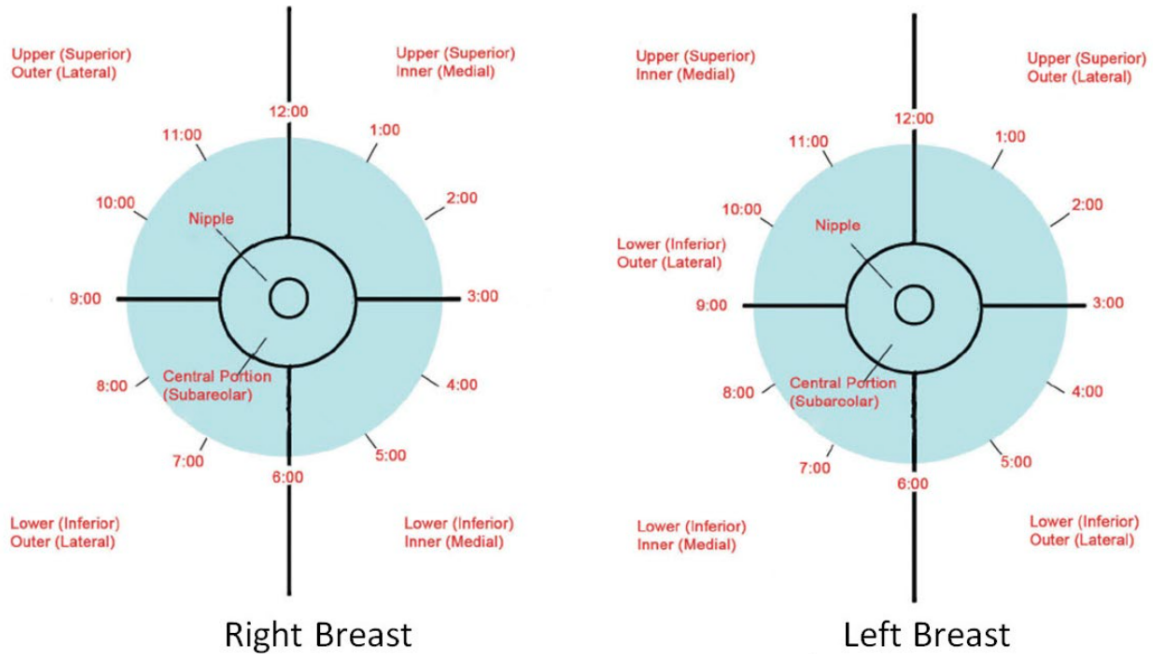
# Breast

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")	___	___																								
<table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;"><b>LT</b></td> <td style="text-align: center;"><b>RT</b></td> <td></td> </tr> <tr> <td>Pain/Tenderness</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Lumps</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Change in breast size</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Areas of skin changes thickening or dimpling</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Excretions or changes of the nipple</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> </table>		<b>LT</b>	<b>RT</b>		Pain/Tenderness	___	___		Lumps	___	___		Change in breast size	___	___		Areas of skin changes thickening or dimpling	___	___		Excretions or changes of the nipple	___	___			
	<b>LT</b>	<b>RT</b>																								
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?																										
<input type="radio"/> Excess bleeding <input type="radio"/> Endometriosis <input type="radio"/> Fibroid cysts <input type="radio"/> Cancer <input type="radio"/> Other																										
5. Has anyone in your family ever been treated for breast cancer?	___	___																								
If yes, note age and survival <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter																										
Age diagnosed _____ Result of Treatment _____																										
6. Have you ever been diagnosed with breast cancer?	___	___																								
If yes, date: _Month _____ Year _____																										
Cancer type <input type="radio"/> Local <input type="radio"/> Metastatic <input type="radio"/> Lymph node involvement																										
Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple																										
Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple																										
Treatment <input type="radio"/> Surgery <input type="radio"/> Chemo <input type="radio"/> Radiation <input type="radio"/> None																										
If surgery; <input type="radio"/> Mastectomy <input type="radio"/> 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 _____ <input type="radio"/> Silicone <input type="radio"/> Saline																										
Experience: <input type="radio"/> Problems <input type="radio"/> No problems																										
9. Have you ever had any biopsies or any other surgeries to your breasts	___	___																								
If yes, date _____																										
Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple																										
Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple																										
Results <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Calcifications																										

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

## Clock and Quadrants of the Breast



- |  | Yes | No  |
|--|-----|-----|
| 10. Have you ever taken contraceptive pills for more than one year?<br>If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years | ___ | ___ |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)?<br>If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> 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***

- |   | <b>Yes</b> | <b>No</b> |
|---|------------|-----------|
| 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 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 area below. | —          | —         |

## ***Abdomen & Lower Back***

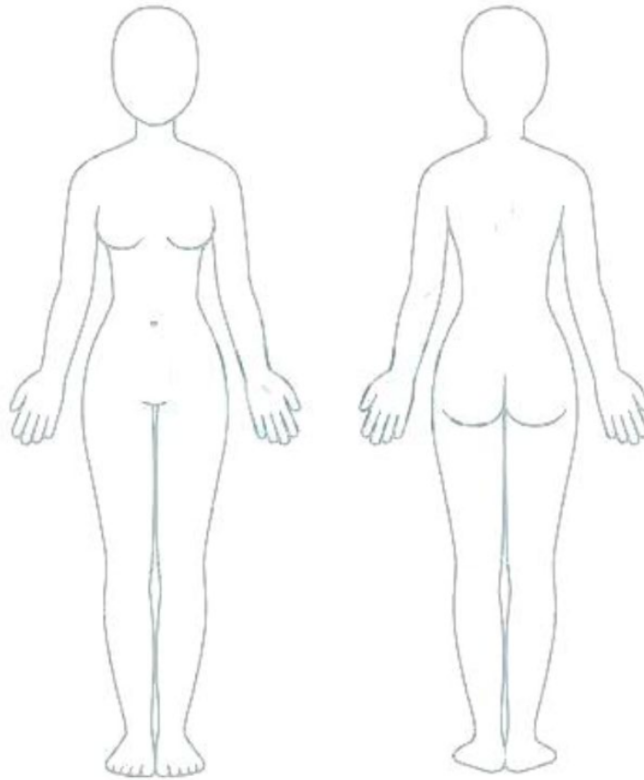
1. Do you suffer with acid reflux or other digestive problems?      Yes    No	3. Have you had surgery or disease in the:	
2. Do you suffer pain in the:	Stomach?	Yes    No
Stomach?      Yes    No	Spleen(Upper Left) ?	Yes    No
Below R Breast?      Yes    No	Liver(Upper Right) ?	Yes    No
Below L Breast?      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?      —      —

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 \_\_\_\_\_