

Confidential Questionnaire

Breast

Name _____ Birth Date _____ Today's Date _____
 Address _____ City _____ State _____ Zip _____
 Phone Number Home _____ Cellular _____ Work _____
 E-Mail Address _____
 Referring Physician _____

Is there a specific reason or concern for this 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? | _____ | _____ | _____ |
| 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 | | | |
| 7. Have you ever been diagnosed with any other breast disease? | _____ | _____ | _____ |
| If yes, <input type="radio"/> Cysts/fibrocystic <input type="radio"/> Fibro Adenoma <input type="radio"/> 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 | | | |

Yes	No
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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
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 ___

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

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. It does not replace any other breast examination.

Patient 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.

Patient Signature _____ Today's Date _____

Thermography Solutions

GENERAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age : _____

Gender: _____

Genetic Background: _____

Highest Education

Level: _____

Job Title: _____

Nature of Business _____

Primary Address: Street: _____ Apt # _____

City: _____ State: _____ Zip: _____

Alternate Address: Street:: _____ Apt

No. _____

City: _____ State: _____ Zip: _____

Home Phone

1: _____

Home Phone

2: _____

Work Phone: _____

Cell Phone: _____

Fax: _____

Email: _____

Emergency Contact: Name: _____

Phone Number: _____

Address: _____ Apt No. _____

City: _____ State: _____ Zip: _____

Physician: Name: _____ Phone

Number: _____

Fax: _____

Referred by:

CONSENT TO USE MEDICAL IMAGES AND HISTORY

I, of do hereby give perpetual permission to **Physicians Insight** and its affiliates to use my images, case history and any supporting documentation in case reviews, peer review and advertising **provided that:**

- a. My identity is not directly or indirectly disclosed (except in confidentiality to the peer review board).
- b. Sufficient case matter is quashed to protect my identity as necessary.
- c. **Physicians Insight** and myself jointly own copyright to material supplied by myself, and copyright can not be inferred onto other entities without my express written permission.
- d. The information supplied shall not be used to cause harm or defame to any other person or profession.

2. Should these stipulations be breached, this consent is to be considered immediately revoked and all materials relevant to my case returned or destroyed.

3. Signed Dated, 2016

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How your images, documents and history may be used

Physicians Insight as a member of the Institute for the Advancement of Medical Thermology (IAMT) is currently compiling a database of case studies for use in future statistical analysis, case studies for teaching purposes, correlational studies and an image base for publicity and public education with known, accurate case histories.

Your identity (including information that could be suspected of leading to your identity) remains completely confidential, with only the case reviewers of the IAMT even finding out your name (to verify any facts regarding your case).

What will not happen is any other practitioner or other organization requesting copies of your records, approaching you directly for further information or soliciting you for any further studies. Any copies of test results etc. that are passed on to us as a part of your case study will be edited to remove your name, address and any other contact or identity details before being used further.

Should you be asked to be a part of an ongoing study by us, all further imaging that forms a part of that study will of course be without charge as a thank you for your co-operation.

We thank you for your help. Your contribution is very much appreciated and not taken for granted.

Authorization to Use or Disclose Protected Health Information

Thermography Solutions

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, *Thermography Solutions* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Physicians Insight, LLC

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: ____/____/____ through ____/____/____

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date

Thermography Preparation & Recommendations

Prior to the appointment, the patient must be advised:

- **No breast surgery, chemotherapy or radiation treatments 2 months prior.**
- **No breast biopsy for one month prior.**
- **Lactation: Imaging is recommended if there is a problem or concern, but a baseline is not recommended for at least 3 months after the last active breast-feeding.**

24 Hours Prior

- **Avoid exercise or heavy physical activity.**
- **No massage or lymph treatments.**
- **No chiropractic adjustments.**
- **No saunas, steam bath or hot tub.**
- **No hot or cold packs.**

Day of Exam:

● **Avoid heavy makeup. Any oil-based products on the body will affect accurate detection**

by the camera.

- **Avoid deodorant or creams on the skin, especially oils.**
- **Absolutely no heat lamps or sunburn. You will have to reschedule.**
- **Do not shave area to be imaged.**
- **For head imaging, do not eat for at least 2 hours before imaging and no chewing gum.**
- **No coffee or cigarettes for at least 2 hours before imaging.**
- **Avoid A/C in the car blowing directly on the patient. It takes hours for the body to equilibrate. This recommendation is vital during the summer.**
- **Patient must remove all jewelry in the area to be imaged**