Confidential Questionnaire

Women's/Men's Health Screening 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? ___ ___

   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? ___ ___

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?			___	___
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

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

	Yes	No
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

	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 ___		

Chest, Heart & Lungs

	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 ever had surgery to your:		
Heart?	___	___
Lungs?	___	___
Mid to upper back?	___	___
5. Do you have asthma or shortness of breath?	___	___
6. Do you currently smoke?	___	___
7. Have you smoked in the past 5 years?	___	___

Abdomen & Lower Back

Yes No	Yes No
1. Do you suffer with acid reflux or other digestive problems? Yes___ No___	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___

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

___

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, corelational 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.**