Confidential Questionnaire

Comprehensive Full Body

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cell)_____(work)_____

Email_____ Referred by: _____

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

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___

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?

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

----------✂----------

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.**