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?
   ○ 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 ___

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.*

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.

Client Signature ____Today's Date_____________