

Confidential Questionnaire

Men's Comprehensive Full Body

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ (cellular) _____ (work) _____

E-Mail Address _____

Referring 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?

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___

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

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.

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 _____