

Confidential Questionnaire

Men's Health Study 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?

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? | ___ | ___ |

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

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.

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 _____