

# Breast Health History

Imaging Center \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Scan: \_\_\_\_\_

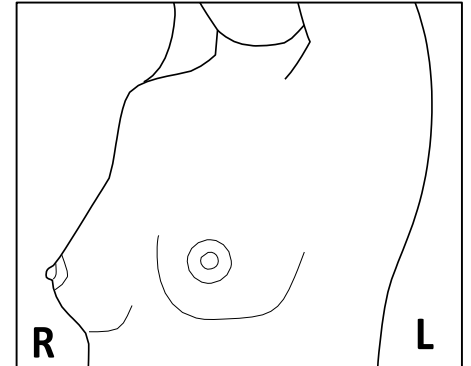
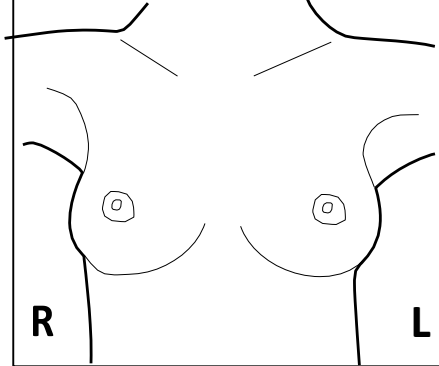
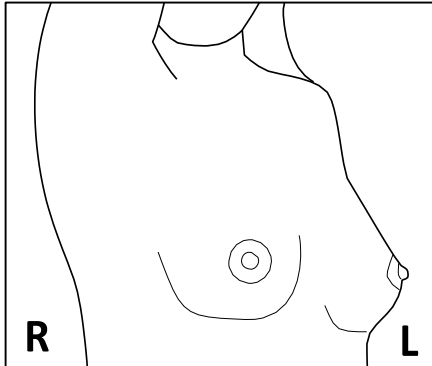
Date of Birth: \_\_\_\_\_ Sex: F  M  Initial Scan  Follow-up Scan

Describe any current breast concerns such as lumps, pain, skin changes, radiographic findings or other concerns:

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## MARK THE AREA OF ANY CURRENT CONCERN ON THE DIAGRAM:



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Last Physical Breast Examination by a Health Care Provider:  None

Date: \_\_\_\_\_ Results:  Normal Other \_\_\_\_\_

Last Mammogram:  None

Date: \_\_\_\_\_  Right  Left  Both

Results:  Normal Other \_\_\_\_\_

Last Breast Ultrasound:  None

Date: \_\_\_\_\_  Right  Left  Both

Results:  Normal Other \_\_\_\_\_

Last Breast MRI:  None

Date: \_\_\_\_\_  Right  Left  Both

Results:  Normal Other \_\_\_\_\_

Breast Biopsy:  None

Date: \_\_\_\_\_  Right  Left  Both

Results:  Benign  Pre-Cancer  Cancer

**Section 1: Breast Cancer**  None  Left  Right  Both Date of Diagnosis: \_\_\_\_\_

Cancer Treatment:

Lumpectomy: Date: \_\_\_\_\_  Mastectomy: Date: \_\_\_\_\_

Reconstruction: Date: \_\_\_\_\_  Radiation treatment: Date of last treatment \_\_\_\_\_

Other treatment \_\_\_\_\_

**Section 2: General**

Benign Breast Surgery:  None Lumpectomy: Date: \_\_\_\_\_  Right  Left

Implants: Date: \_\_\_\_\_ Reduction: Date: \_\_\_\_\_

Fibrocystic breasts, Breast Cysts, or General Breast Lumpiness  Yes  No

Other benign breast conditions:  None  Yes \_\_\_\_\_

Currently Breast feeding:  No

Yes - Last Breast Nursed:  Right  Left Breast Most Favored:  Right  Left

Pregnant:  Yes  No - current cycle day (# of days since 1st day of period): \_\_\_\_\_

Menopause:  No  Yes - Age of last menses: \_\_\_\_\_

Currently experiencing symptoms of:  Menopause  Perimenopause  Neither

Both ovaries removed:  Yes - Check only if both have been removed  No

Family history of breast cancer:  Yes  No

Past injury to the breasts:  None  Right  Left  Both Date of Injury: \_\_\_\_\_

**Section 3: Selected Hormones and Factors Effecting Them**

Current Hormones:  None

Estrogen  Progesterone  Testosterone  Thyroid hormone

Current supplements to support the following:  None

Breast Health  Hormonal Balance  Inflammation  Thyroid Function

Are you currently engaged in any lifestyle activities or diet designed to:  None

Promote breast health  Reduce inflammation  Promote hormonal balance

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**PLEASE DO NOT WRITE IN THIS SECTION**

Tech: \_\_\_\_\_ Patient Temp: \_\_\_\_\_ F Laboratory Temp: \_\_\_\_\_ C

## INFORMED CONSENT FOR TESTING PROCEDURE

Thermal Breast Imaging (otherwise known as breast thermography) detects and visualizes the thermal emissions (temperature) occurring at the surface of the breasts. The purpose of the examination is to detect signs of inflammation or unusual blood vessel activity that could suggest risk for current and/or future risk for cancer. Initial \_\_\_\_\_

I understand that Thermal Breast Imaging is used only as an adjunct to primary screening examinations such as physical breast examination, mammography, breast ultrasound and breast MRI and does not replace any other breast examination or screening. I also understand that thermal imaging does not and cannot directly detect or be used to diagnose breast cancer. Nor can it rule out the presence of breast cancer since some cancers do not produce sufficient temperature changes at the surface of the breasts to be seen with thermography. Therefore, breast cancer may still be present despite thermal imaging revealing a low risk. For that reason, thermal imaging does not replace any other breast examination. All breast concerns including but not limited to skin changes, nipple discharge, lumps or other abnormalities, clinical findings and radiographic findings require evaluation by a medical doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing cancer to be detected. Initial \_\_\_\_\_

I confirm that I have followed the written pre-examination protocols for breast imaging provided to me before the examination. I understand that if I did not receive or follow these protocols, the accuracy of my examination may be compromised. Initial \_\_\_\_\_

By signing below, I hereby acknowledge that (1) I have read and understood each of the above paragraphs; (2) I have had an opportunity to ask any questions I may have had; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information with respect to thermal imaging to make an informed decision to undergo the procedure; (5) I understand no guarantee or warranty is being made that all risk for current and/or future cancer will be detected; and (6) I hereby authorize and consent to thermal imaging

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## STATEMENT OF INDEPENDENT OPERATIONS:

I understand and agree that Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services (collectively referred to as "Kane Interpretive Services") is a California based company that contracts with the provider of your imaging services solely for the purpose of interpreting and reporting thermal imaging scans. Your provider is not an employee, officer, director, partner, representative or agent of Kane Interpretive Services. Nor is Kane Interpretive Services an employee, officer, director, partner, representative or agent of your provider. Kane Interpretive Services is a wholly separate business entity from your provider and does not oversee or supervise your provider's thermography operations. Kane Interpretive Services is not involved in the design, manufacture, marketing, sale, rental, distribution, installation, inspection, repair or modification of any machinery or products used by your provider. Rather, Kane Interpretive Services is an independent contractor hired by your provider solely to interpret thermal imaging data and to report the results. Kane Thermal Interpretive Services does not control, nor have the right to control, your provider's business, including its equipment, operations, advertising and/or representations. Kane Interpretive Services makes no promises, warranties or representations, express or implied, as to your provider's services. In addition, Kane Interpretive Services owes no duty of care to me in connection with provider's services, including no duty to screen provider, no duty to protect or warn me of any actions or inactions of provider and no duty to investigate, communicate or mitigate any risks, known or unknown, relating to provider's services. I assume all duty of reasonable care to select, screen and monitor provider's services for my own safety and protection.

By signing this Statement of Independent Operations, I understand and agree with the foregoing and further agree that Dr. Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services is only responsible to me for the content of the thermal imaging report and its accompanying reporting guide.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Cranial Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Scan: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F  M  Initial Exam  Follow-up Exam

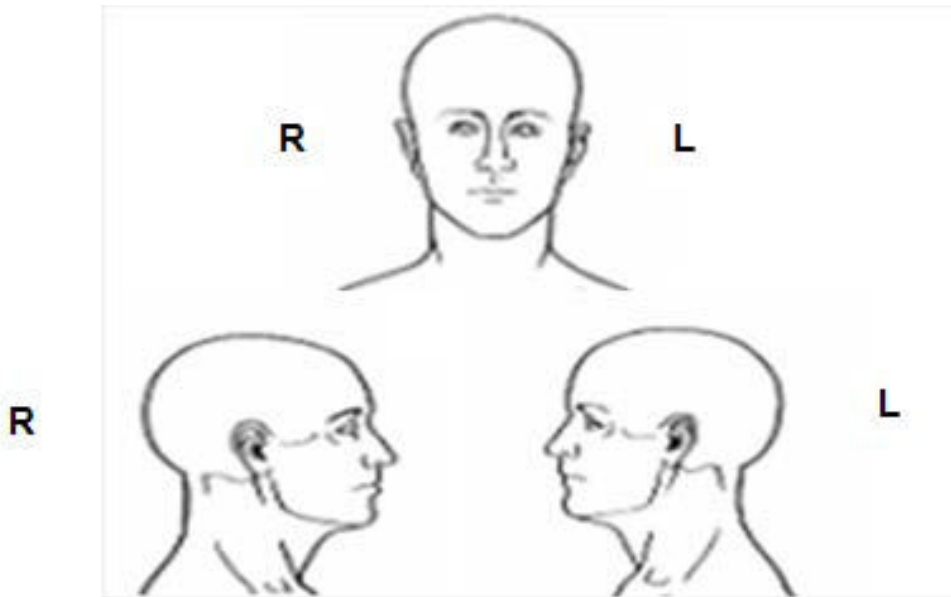
Please describe any current concerns with:

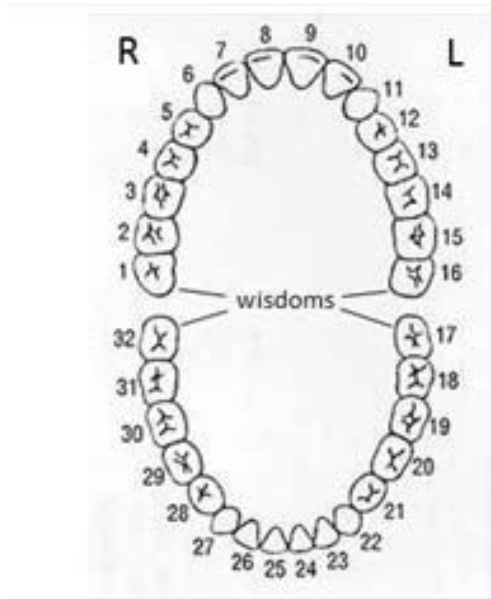
## Face and Anterior neck:

- Facial Pain
- Facial Numbing
- Tooth/Tooth Socket Pain
- TMJ Pain or Clicking
- Sinus Concerns
- Allergies
- Thyroid
- Lymph Node
- Headaches

Please Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Place an "x" on the diagram in the area of concern.





History of:  None

Stroke

Cardiovascular Disease

Dizziness

Fainting

Please Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

History of: Root Canal  Yes  No

Wisdom Tooth Extraction  Yes  No

Please Describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please do not write in this section**

Tech \_\_\_\_\_

Patient T = \_\_\_\_\_ F

Laboratory Temperature \_\_\_\_\_ C

**Additional Technician Notes**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## **INFORMED CONSENT FOR TESTING PROCEDURE**

Thermal imaging is a technology which measures the surface temperature of the body using infrared cameras and is analyzed to provide physiological information as an adjunct to standard screening and diagnostic testing. Initial \_\_\_\_\_

I understand that thermal imaging does not and cannot directly detect or be used to diagnose injury or disease of any kind and that the information is designed to be used with other examinations as an aid to the diagnostic process. Nor can it rule out the presence of injury or disease since some conditions do not produce sufficient temperature changes at the surface of the body to be seen with thermography. Therefore, injury or disease may still be present despite a lack of thermal findings present on examination. All concerns require evaluation by a doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing condition to be detected. Initial \_\_\_\_\_

I further understand that not all dental, thyroid, and other conditions of the head and neck will produce thermal findings that will enable detection. Therefore I understand that this test cannot determine if these structures are diseased or healthy and it cannot diagnose disease. It is a functional test which may provide general regions to evaluate more thoroughly by a health care provider. It cannot replace or rule out the need for examination or additional testing. Initial \_\_\_\_\_

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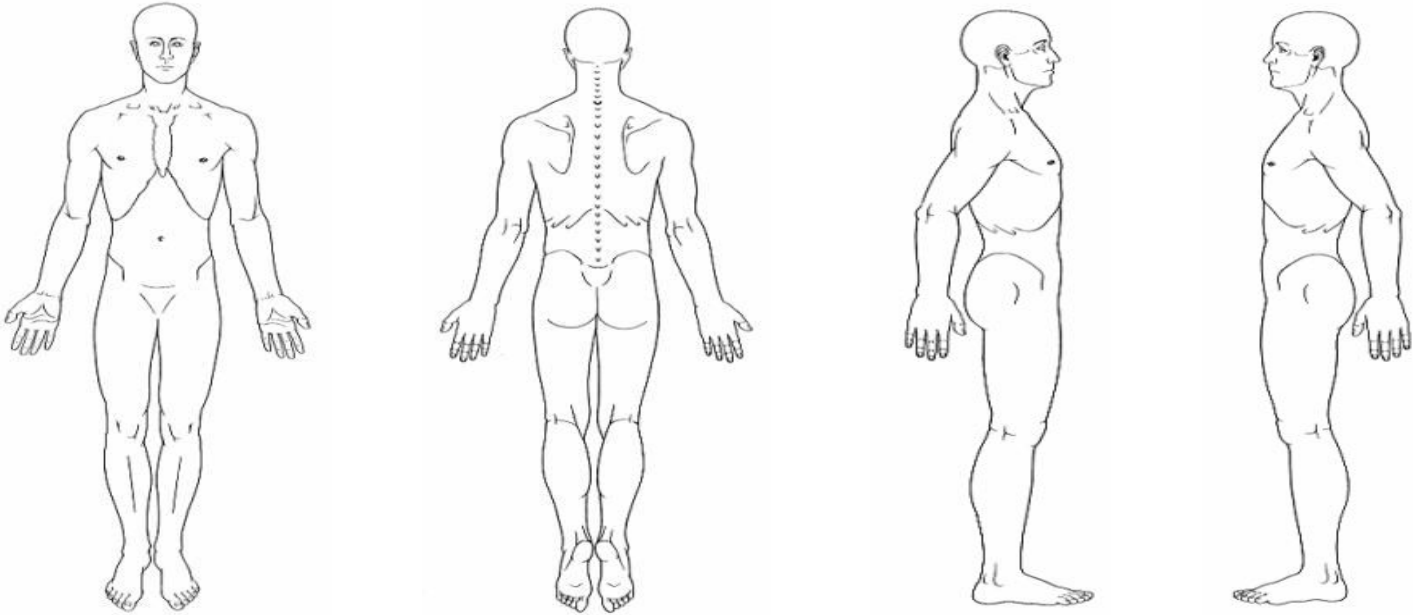
\_\_\_\_\_  
Date

# Full Body and Pain History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Scan: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: F  M  Initial Exam:  Follow-up Exam

Mark the location of symptoms with an "X" and label it as sharp, dull, burning, aching, etc.



## Please Note Level of Pain

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10  
Mild: Annoyance                      Moderate: Some Limitations                      Severe: Pain Killers Needed

Describe your symptoms: \_\_\_\_\_

\_\_\_\_\_

How and when did this start? \_\_\_\_\_

\_\_\_\_\_

Were you examined for this complaint? Date and Results \_\_\_\_\_

\_\_\_\_\_

What increases your symptoms? \_\_\_\_\_

\_\_\_\_\_





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