Confidential Questionnaire

Breast Study

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")	___	___
2. Are any of the above symptoms cycle related?	___	___
3. Are you still having your periods? If yes: Date of last period _____	___	___
4. Have you had a surgical hysterectomy?	___	___
5. Has anyone in your family ever been treated for breast cancer?	___	___
6. Have you ever been diagnosed with breast cancer?	___	___

	LT	RT
Pain/Tenderness	___	___
Lumps	___	___
Change in breast size	___	___
Areas of skin changes thickening or dimpling	___	___
Excretions or changes of the nipple	___	___

If yes, date_____ Complete ___ Partial ___
Reason for hysterectomy?
o Excess bleeding o Endometriosis o Fibroid cysts o Cancer o Other

If yes, note age and survival o Mother o Grandmother o Sister o Daughter
Age diagnosed _____ Result of Treatment_____

If yes, date: Month _____ Year _____

Cancer type	o Local	o Metastatic	o Lymph node involvement	
Left breast	o Inner	o Outer	o Nipple	
Right breast	o Inner	o Outer	o Nipple	
Treatment	o Surgery	o Chemo	o Radiation	o None
If Surgery;	o Mastectomy	o Lumpectomy		

7. Have you ever been diagnosed with any other breast disease? ___ ___

   If yes, o Cysts/fibrocystic o Fibro Adenoma o Mastitis/inflammatory breast disease

8. Have you had any cosmetic breast surgery or implants? ___ ___

   If yes, date_____ o Silicone o Saline o Reduction

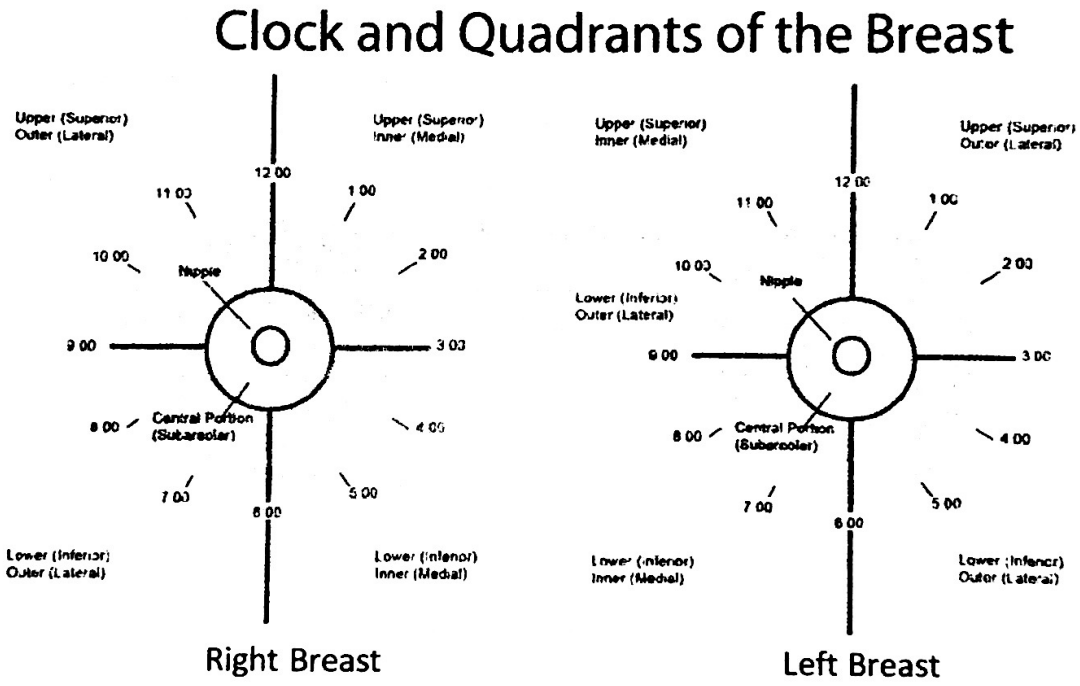
   Experience: o Problems o No problems

9. Have you ever had any biopsies or any other surgeries to your breasts ___ ___

   If yes, date_____

Left breast	o Inner	o Outer	o Nipple
Right breast	o Inner	o Outer	o Nipple
Results	o Negative	o Positive	o Calcifications

Mark on the following graph to indicate location of pain, surgery or lumps:



	Yes	No
10. Have you ever taken contraceptive pills for more than one year?	___	___
If yes, o Currently o Less than 5 years o More than 5 years		
11. Have you had pharmaceutical hormone replacement therapy (HRT)?	___	___
If yes, o Currently o Less than 5 years o 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?

INFORMED CONSENT FOR IMAGING
FULL-BODY and/or BREAST

Safe Body Imaging
FOR THE HEALTH OF IT

Infrared thermal imaging is a technology which measures the surface temperature of the body using infrared cameras, and is analyzed to provide physiological information as a complimentary adjunct to other standard screening and diagnostic testing.

I understand that thermal imaging does not directly detect, or should be used to diagnose a specific disease.There is no stand alone screening test that can "diagnose" cancer, of which can only be diagnosed with a biopsy and pathologist. The information provided with infrared thermal imaging is designed to be used with other standard screening tests as an aid to determine a proper diagnosis by a medical professional. Also, thermography cannot rule out the presence of a disease, since some conditions do not produce sufficient temperature changes immediately on the surface of the body to be seen with thermography I also understand that an injury or a disease could still be present despite a lack of thermal findings presented at the time of imaging. All health concerns require evaluation by a medical professional regardless of the information provided in a thermography report. Infrared thermal imaging as a stand alone detection for screening is not suggested, as it is with any other standard medical screening test.

I also understand that not all organ systems and medical conditions will produce clear thermal findings that will enable thermal detection at the time of imaging. Therefore, I understand that thermography cannot determine or diagnose if an organ or the body is diseased or healthy. It is a functional test which can provide specific areas to be evaluated more thoroughly by a medical professional. It cannot replace or rule out the need for a complete medical examination or additional testing ordered by a medical professional.

I confirm that I have followed the written pre examination protocol for thermal imaging prior to my imaging appointment, of which is made public on the website under forms. I understand that if I did not review and follow the protocol provided, the accuracy of my examination may be compromised. If a re-scan is warranted, due to lack of adherence to following the prep instructions, there will be a charge for a new scan.

By signing this form below I hereby acknowledge that (1) I have read and understood all the above paragraphs; (2) I was given the opportunity to ask questions; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information to make an informed decision to undergo thermal imaging; (5) I understand no guarantee or promises are being made that any risk for current and/or future injury or disease can or will be detected at the time of imaging; and (6) I hereby authorize and consent to thermal imaging on this date.

Print Name: _____ **Date:**_____

Signature: _____