Confidential Questionnaire

Women's Comprehensive Full Body

Name _____ Birth Date _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cellular _____ Work Phone _____
Email _____ 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.

Do you have any special concerns or a specific reason for this exam?

_____

_____

_____

Head & Neck

	Yes	No
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? Wisdom teeth removed_____, How many? 4_____, 3_____, 2_____, or 1____ Teeth removed without replacement____, How many? ____ Root Canals_____, How many?_____ Implants _____ Dentures_____ Gum Disease_____. Treated_____, Untreated_____	○	○
12. Have you had dental cleaning in the past 7 days?	○	○

Breast

Is there a specific reason or concern for this breast exam?

_____

_____

_____

	Yes	No
1. Have you recently had any of these breast symptoms?	○	○
	LT	**RT**
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin changes thickening or dimpling	○	○
Excretions of the nipple	○	○
	Yes	**No**
2. Are any of the above symptoms cycle related?	○	○
3. Are you still having periods? If yes, date of last period_____	○	○
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, ○ Mother ○ Grandmother ○ Sister ○ Daughter Age diagnosed _____ Result of Treatment_____	○	○
6. Have you ever been diagnosed with breast cancer? If yes, date 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 your 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 ____	○	○

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?		○	○

Abdomen & Lower Back

	Yes	No	Have you had surgery or disease in the:	Yes	No
1. Do you suffer with acid reflux or other digestive problems?	○	○	Stomach?	○	○
2. Do you suffer pain in the:			Spleen(Upper Left) ?	○	○
Stomach?	○	○	Liver(Upper Right) ?	○	○
Below R Breast?	○	○	Kidneys ?	○	○
Below L Breast?	○	○	Intestines ?	○	○
Abdomen?	○	○	Abdomen ?	○	○
Lower Back?	○	○	Lower Back?	○	○
Pelvic Region?	○	○	Pelvic Region?	○	○
Have you consumed alcohol in the past 24 hours?				○	○

Legs & Feet

	LT	RT	Check only if "Yes"	LT	RT
1. Do you suffer pain in the:			2. Have you had surgery to:		
Leg?	○	○	Leg?	○	○
Sciatica?	○	○	Sciatica?	○	○
Buttocks/Hip?	○	○	Buttocks/Hip?	○	○

Knees?	○	○	Knees?	○	○
Ankles?	○	○	Ankles?	○	○
Feet?	○	○	Feet?	○	○

Arms & Hands

(Check only if "yes")

1. Do you suffer 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.*

Patient 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.

Patient Signature _____ Today's Date _____

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