Breast Thermography Confidential Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any practitioner you specify (see other side).

Patient ID:	# Previous:
Tech use only	THERM: Base1 Base2 Annual Comp FULL UPPER LOW BR ROI

Today's Date: First scan? Y N

Name: ______________________________ Date of Birth: ______________
First Middle Initial Last

Address/city/st/zip: ______________________________

Home Phone: ______________ Cell Phone: ______________ Call Preference: Home / Cell

Email: ______________________________

Referred by: ______________ Doctor ______________ Send report to doctor? ______

Sign consent on other side

	Yes	No	
1.	☐	☐	**Do you have any close relative who has had breast cancer?**
2.	☐	☐	**Have you ever been diagnosed with breast cancer?**
3.	☐	☐	**Have you ever been diagnosed with any other breast disease? Disease type:** ☐ Cystic ☐ Abscess ☐ Fibrocystic ☐ Mastitis
4.	☐	☐	**Have you had any biopsies or surgeries to your breasts?** (see other side)
5.	☐	☐	**Have you had any breast cosmetic surgery or implants?** (see other side)
6.	☐	☐	**Have you had a mammogram in the past 12 months?**
7.	☐	☐	**Have you had a mammogram in the past 5 years?**
8.	☐	☐	**Have you had abnormal results from any breast testing?**
9.	☐	☐	**Have you ever taken a contraceptive pill for more than 1 year?** (How long?____________)
10.	☐	☐	**Have you suffered with cancer of the womb?**
11.	☐	☐	**Have you had pharmaceutical hormone replacement therapy?** (How long?____________)
12.	☐	☐	**Do you have an annual physical examination by a doctor?**
13.	☐	☐	**Do you perform a monthly breast self exam?**

14. How many mammograms have you had in total? _________

15. What was your age when you had your first mammogram ? _______________

16. How many births have you had? ________ Your age at birth of first child: ___________

17. Did your periods start before the age of 12?________ Or finish after the age of 50? _______

18. Do you smoke? ☐ **Yes** ☐ **Never** ☐ **Not in last 12 months** ☐ **Not in last 5 years**

Have you recently had any of these breast symptoms:	**Right Breast:**	**Left Breast:**
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

☐ **Hysterectomy? If yes:** ☐ **Partial or** ☐ **Full Surgery Date:________________ Age: _______**

Other surgeries? ______________________________

If close relative had breast cancer, who? ___________ Details:______________________________

Recent Detox? Regimen change? other?: ______________________________

Recent or current illness?: ______________________________

Patient Name: ____ Date: ____________

Diagnosed with breast cancer:

Cancer type: ☐ Metastatic ☐ Local ☐ Lymph node involvement

When diagnosed: Month _________ Year ________________________________

Where (left breast): ☐ UO ☐ UI ☐ LO ☐ LI ☐ Nipple

Where (right breast): ☐ UO ☐ UI ☐ LO ☐ LI ☐ Nipple

Treatment: ☐ Surgery ☐ Chemo ☐ Radiation ☐ Other _______ ☐ None

Diagnosed with other breast disease:

Disease type: ☐ Fibrocystic ☐ Cystic ☐ Mastitis ☐ Abscess ☐ Other

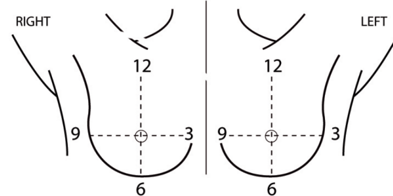
Breast biopsies or surgery:

Where (left breast): ☐ UO ☐ UI ☐ LO ☐ LI ☐ Nipple

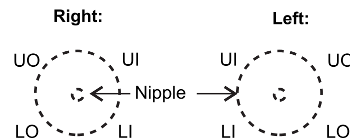
Where (right breast): ☐ UO ☐ UI ☐ LO ☐ LI ☐ Nipple

Skin lesions / scaring:

(please illustrate)



LEGEND:



UO = upper outer
LO = lower outer
UI = upper inner
LI = lower inner

____

____

____

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self evaluation or self diagnosis.

I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ____ **Date:** __________

Please submit a copy of this report to: (Physician's name) ________________________________

Doctor's address: ____

Signature ____ **Date:** __________