

Confidential Questionnaire

Breast

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") Yes No
- | | LT | RT |
|--|-----------------------|-----------------------|
| Pain/Tenderness | <input type="radio"/> | <input type="radio"/> |
| Lumps | <input type="radio"/> | <input type="radio"/> |
| Change in breast size | <input type="radio"/> | <input type="radio"/> |
| Areas of skin changes thickening or dimpling | <input type="radio"/> | <input type="radio"/> |
| Excretions or changes of the nipple | <input type="radio"/> | <input type="radio"/> |
2. Are any of the above symptoms cycle related? Yes No
3. Are you still having your periods? Yes No
If yes, date of last period _____
4. Have you had a surgical hysterectomy? Yes No
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? Yes No
If yes, note age and survival Mother Grandmother Sister Daughter
Age diagnosed _____ Result of Treatment _____
6. Have you ever been diagnosed with breast cancer? Yes No
If yes, date Month _____ Year _____
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? Yes No
If yes, Cysts/fibrocystic Fibro Adenoma Mastitis/inflammatory breast disease
8. Have you had any cosmetic breast surgery or implants? Yes No
If yes, date _____ Silicone Saline
Experience: Problems No problems

Yes	No
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9. Have you ever had any biopsies or any other surgeries to your breasts Yes No
 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? Yes No
 If yes, Currently Less than 5 years More than 5 years
11. Have you had pharmaceutical hormone replacement therapy (HRT)? Yes No
 If yes, Currently Less than 5 years More than 5 years
12. Do you have an annual physical examination by a doctor? Yes No
13. Do you perform a monthly breast self exam? Yes No
14. Have you ever smoked? Yes No
15. Have you ever been diagnosed with diabetes? Yes No
16. Total mammograms _____
17. Date of last mammogram _____ Were you re-called? Yes No
18. Your age at your first mammogram? _____
19. Number of full term pregnancies? _____
20. Have you had breast ultrasound? Yes No
 If yes...Date: ___/___/___ Left ___ Right ___ Results: Negative ___ Positive ___
21. Have you had breast MRI? Yes No
 If yes...Date: ___/___/___ Left ___ Right ___ Results: Negative ___ Positive ___

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 _____