

Confidential Questionnaire

Men's Comprehensive Full Body

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ (cellular) _____ (work) _____

E-Mail Address _____

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.

Yes No

Head & Neck

1. Do you suffer with headaches? Yes No
If yes, once a month or less **more** than once a month
2. Do you have allergies? Food _____ Environmental _____ Yes No
3. Do you have TMJ or does your jaw click? Yes No
4. Do you currently have a cold? Yes No
5. Are you being treated for a thyroid disorder? Type _____ Yes No
6. Do you have neck pain? Yes No
7. Do you have upper back pain? Yes No
8. Do you have a history of carotid artery disease? Yes No
9. Do you have a family history of stroke? Yes No
10. Do you currently suffer with sinus problems? Yes No
11. Do you have history of dental problems? Yes No
Root canals _____ Gum disease _____ Implants _____
Non-replaced extractions _____ Dentures _____
12. Have you had dental cleaning in the past 7 days? Yes No

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with: | | |
| Heart disease? | <input type="radio"/> | <input type="radio"/> |
| Lung disease? | <input type="radio"/> | <input type="radio"/> |
| Upper spine disorders? | <input type="radio"/> | <input type="radio"/> |
| 2. Do you suffer with upper back pain? | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain? | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had surgery to your: | | |
| Heart? | <input type="radio"/> | <input type="radio"/> |
| Lungs? | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back? | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you currently smoke? | <input type="radio"/> | <input type="radio"/> |
| 7. Have you smoked in the past 5 years? | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer with acid reflux or other digestive problems?	<input type="radio"/>	<input type="radio"/>	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	<input type="radio"/>	<input type="radio"/>
Stomach?	<input type="radio"/>	<input type="radio"/>	Spleen(Upper Left) ?	<input type="radio"/>	<input type="radio"/>
Below R Breast?	<input type="radio"/>	<input type="radio"/>	Liver(Upper Right) ?	<input type="radio"/>	<input type="radio"/>
Below L Breast?	<input type="radio"/>	<input type="radio"/>	Kidneys ?	<input type="radio"/>	<input type="radio"/>
Abdomen?	<input type="radio"/>	<input type="radio"/>	Intestines ?	<input type="radio"/>	<input type="radio"/>
Lower Back?	<input type="radio"/>	<input type="radio"/>	Abdomen ?	<input type="radio"/>	<input type="radio"/>
Pelvic Region?	<input type="radio"/>	<input type="radio"/>	Lower Back?	<input type="radio"/>	<input type="radio"/>
			Pelvic Region?	<input type="radio"/>	<input type="radio"/>

Have you consumed alcohol in the past 24 hours?

Legs & Feet

Check only if “Yes”

1. Do you suffer pain in the:	LT	RT	2. Have you had Surgery to:	LT	RT
Leg?	<input type="radio"/>	<input type="radio"/>	Leg?	<input type="radio"/>	<input type="radio"/>
Sciatica?	<input type="radio"/>	<input type="radio"/>	Sciatica?	<input type="radio"/>	<input type="radio"/>
Buttocks/Hip?	<input type="radio"/>	<input type="radio"/>	Buttocks/Hip?	<input type="radio"/>	<input type="radio"/>
Knees?	<input type="radio"/>	<input type="radio"/>	Knees?	<input type="radio"/>	<input type="radio"/>
Ankles?	<input type="radio"/>	<input type="radio"/>	Ankles?	<input type="radio"/>	<input type="radio"/>
Feet?	<input type="radio"/>	<input type="radio"/>	Feet?	<input type="radio"/>	<input type="radio"/>

Do you have any special concerns or are there any details related to the information above?

Arms & Hands

(Check only if “yes”)

1. Do you suffer with pain in the:	LT	RT	2. Have you had surgery to:	LT	RT
Shoulder?	<input type="radio"/>	<input type="radio"/>	Shoulder?	<input type="radio"/>	<input type="radio"/>
Elbow?	<input type="radio"/>	<input type="radio"/>	Elbow?	<input type="radio"/>	<input type="radio"/>
Arm?	<input type="radio"/>	<input type="radio"/>	Arm?	<input type="radio"/>	<input type="radio"/>
Hands?	<input type="radio"/>	<input type="radio"/>	Hands?	<input type="radio"/>	<input type="radio"/>

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 _____