Confidential Questionnaire *Women's Health Screening*

Name	Birth Date	Today's Date	
Address	City	StateZip	
Phone Number (home)	_(cellular)	_(work)	
E-Mail Address	Referring Physician	n	

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		
 Do you suffer with headaches? If yes, ○ once a month or less ○ more than once a month 	0	0
2. Do you have allergies?	0	0
3. Do you have TMJ or does your jaw click?	0	0
4. Do you currently have a cold?	0	0
5. Are you being treated for a thyroid disorder?	0	0
6. Do you have neck pain?	0	0
7. Do you have upper back pain?	0	0
8. Do you have a history of carotid artery disease?	0	0
9. Do you have a family history of stroke?	0	0
10. Do you currently suffer with sinus problems?	0	0

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

Breast

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

			Yes	No
1. Have you recently had any of these breast symptoms?		0	0	
	LT	RT		
Pain/Tenderness	0	0		
Lumps	0	0		
Change in breast size	0	0		
Areas of skin thickening or dimpling	0	0		
Excretions of the nipple	0	0		

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2. Are any of the above symptoms cycle related? 0 0 3. Are you still having periods? 0 0 If yes, date of last period 0 0 Have you had a surgical hysterectomy? 0 0 If yes, date 0 Complete 0 Reason for hysterectomy? 0 Complete 0 0 Excess bleeding 0 Endometriosis 0 1 fyes, 0 Mother 0 Grandmother 0 Sister 0 0 1 fyes, 0 Mother 0 Grandmother 0 Sister 0 0 1 1 fyes, 0 Mother 0 Grandmother 0 Sister 0 0 1 1 fyes, date 0 Inner 0 Outer 0 Nipple Treatment 0 Surgery 0 Chemo Radiation 0 0 1 Have you ever been diagnosed with any other breast disease? 0 0 1 fyes, 0 0 0 1 fyes, 0 0		Yes	No
If yes, date of last period	2. Are any of the above symptoms cycle related?	0	0
If yes, date		0	0
Reason for hysterectomy? • Excess bleeding • Endometriosis • Fibroid cysts • Cancer • Other 5. Has anyone in your family ever been treated for breast cancer? • O If yes, • Mother • Grandmother • Sister • Daughter 6. Have you ever been diagnosed with breast cancer? • O • O • O If yes, date • Cancer type • Local • Metastatic • Lymph node involvement Left breast • Inner • Outer • Nipple • Nipple • Nipple Right breast • Inner • Outer • Nipple • None 7. Have you ever been diagnosed with any other breast disease? • O • O • O If yes, or Cysts/fibrocystic • Mastitis/inflammatory breast disease • Fibro Adenoma • O 8. Have you ever been diagnosed with any other surgeries to your breasts? • O • O • O If yes, date • Problems • No problems • O • O • O 8. Have you ever had any biopsics or any other surgeries to your breasts? • O • If yes, date • Silicone • Saline Experience • Problems • No problems • Outer • Nipple	4. Have you had a surgical hysterectomy?	0	0
 Excess bleeding O Endometriosis O Fibroid cysts O Cancer O Other 5. Has anyone in your family ever been treated for breast cancer? O If yes, O Mother O Grandmother O Sister O Daughter 6. Have you ever been diagnosed with breast cancer? Cancer type O Local O Metastatic U Lymph node involvement Left breast O Inner O Outer O Nipple Right breast O Inner O Outer O Radiation O None 7. Have you ever been diagnosed with any other breast disease? O Grif yes, O Cysts/fibrocystic O Mastitis/inflammatory breast disease Fibro Adenoma 8. Have you ever been diagnosed with any other breast disease? O Fibro Adenoma 8. Have you ever had any biopsies or any other surgerizes to your breasts? O If yes, date Left breast O Inner O Outer O Nipple Right breast O Inner O Outer O Saline Experience O Problems O No problems 9. Have you ever taka en ontraceptive pills for more than one year? O 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? O you perform a monthly breast self exam? O thave you ever been diagnosed with diabetes? O tate of your last mammogram Were you re-called? O If we you and mammograms have you had in total? 	If yes, date O Complete O Partial		
If yes, O Mother O Grandmother O Sister O Dughter 6. Have you ever been diagnosed with breast cancer? O O If yes, date Cancer type Local O Metastatic Lymph node involvement Left breast O Inner O Outer O Nipple Right breast Inner O Outer O Nipple Treatment O Surgery O Chemo Radiation O None 7. Have you ever been diagnosed with any other breast disease? O O If yes, O Surgery O 1f yes, O Cystst/fibrocystic O Mastitis/inflammatory breast disease O O If yes, date O O 1f yes, date			
6. Have you ever been diagnosed with breast cancer? 0 0 If yes, date	5. Has anyone in your family ever been treated for breast cancer?	0	0
If yes, date	If yes, \circ Mother \circ Grandmother \circ Sister \circ Daughter		
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? Radiation None 7. Have you ever been diagnosed with any other breast disease? Cysts/fibrocystic Mastitis/inflammatory breast disease Fibro Adenoma Mave you had any cosmetic breast surgery or implants? O If yes, date Problems No problems Slicone Saline Experience Problems No problems If yes, date Inner Outer Nipple Right breast Inner Outer Nipple Right breast Inner Outer Nipple Results Negative Positive Calcifications Have you ever taken contraceptive pills for more than one year?		0	0
Right breast o Inner o Outer o Nipple Treatment o Surgery o Chemo o Radiation o None 7. Have you ever been diagnosed with any other breast disease? O O If yes, o Cysts/fibrocystic o Mastitis/inflammatory breast disease O O If yes, o Cysts/fibrocystic o Mastitis/inflammatory breast disease O O If yes, date		ement	
Treatment o Surgery o Chemo o Radiation o None 7. Have you ever been diagnosed with any other breast disease? 0 0 If yes, o Cysts/fibrocystic o Mastitis/inflammatory breast disease o Fibro Adenoma 0 0 8. Have you had any cosmetic breast surgery or implants? 0 0 0 If yes, date o Silicone o Saline 0 Experience 0 Problems 0 No problems 0 0 9. Have you ever had any biopsies or any other surgeries to your breasts? 0 0 0 If yes, date 0 Outer 0 Nipple 0 0 Right breast 0 Inner 0 Outer 0 Nipple 0 0 Results 0 Negative 0 Positive 0 Calcifications 0 0 10. Have you ever taken contraceptive pills for more than one year? 0 0 0 1 1 9 0 0 0 0 0 0 1 1 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
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If yes, Cysts/fibrocystic Mastitis/inflammatory breast disease 0 Fibro Adenoma 8. Have you had any cosmetic breast surgery or implants? 0 0 If yes, date 0 Silicone 0 Experience 0 Problems 0 0 If yes, date 0 Silicone 0 0 If yes, date 0 O 0 0 If yes, date 0 O 0 0 If yes, date 0 Outer 0 0 If yes, date 0 Outer 0 0 0 Right breast 0 Inner 0 Outer 0 Nipple Results 0 Negative 0 Positive 0 Calcifications 10. Have you ever taken contraceptive pills for more than one year? 0 0 0 1 If yes, 0 Currently Less than 5 years 0 0 11. Have you had pharmaceutical hormone replacement therapy (HRT)? 0 0 0 12. Do you have	Treatment Surgery - Cheme - Tudation	- 1,0110	
If yes, date O Silicone O Saline Experience O Problems O No problems 9. Have you ever had any biopsies or any other surgeries to your breasts? O 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 10. Have you ever taken contraceptive pills for more than one year? O O If yes, O 11. Have you had pharmaceutical hormone replacement therapy (HRT)? O O If yes, O 11. Have you have an annual physical examination by a doctor? O O O 13. Do you perform a monthly breast self exam? O O O 14. Have you ever smoked? O O O 15. Have you ever been diagnosed with diabetes? O O O 16. Date of your last mammograms have you had in total? Were you re-called? O	If yes, O Cysts/fibrocystic O Mastitis/inflammatory breast disease	0	0
Experience Problems No problems 9. Have you ever had any biopsies or any other surgeries to your breasts? If yes, date	8. Have you had any cosmetic breast surgery or implants?	0	0
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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. Date of your last mammogram Were you re-called? • 17. How many mammograms have you had in total? • •	If yes, \circ Currently \circ Less than 5 years \circ More than 5 years		
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17. How many mammograms have you had in total?	15. Have you ever been diagnosed with diabetes?	0	0
17. How many mammograms have you had in total?	16. Date of your last mammogram Were you re-called?	0	0
18. Your age at your first mammogram?			
	18. Your age at your first mammogram?		

Your thermal imaging baseline reports will provide information abo	bout current and future conditions only and does not
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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.

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

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.

Procedure: You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings.

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

Patient Signature

Today's Date

Yes

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19.	Number of full term pregnancies?	

- 20. Your age at birth of your first child?
- 21. Age when you started your period?

Lung disease?

Upper spine disorders?

3. Do you suffer with chest pain?

Mid to upper back?

6. Do you currently smoke?

5. Do you have asthma or shortness of breath?

7. Have you smoked in the past 5 years?

Heart?

Lungs?

2. Do you suffer with upper back pain?

4. Have you ever had surgery to your:

Chest, Heart & Lungs	
1. Have you been diagnosed with:	
Heart disease?	