

Patient Name: _____ Date: _____

Birthdate: _____ Phone: _____

Address: _____

City: _____ Zip: _____

Email: _____ Doctor: _____

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.

Breast Thermography Confidential Questionnaire

YES NO

- 1. Do you have any close relative who has had breast cancer? Who _____
 - 2. Have you ever been diagnosed with breast cancer?
 - 3. Have you ever been diagnosed with any other breast disease? (i.e. fibrocystic).....
 - 4. Have you had any biopsies or surgeries to your breasts?.....
 - 5. Have you had any breast cosmetic surgery or implants?.....
 - 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?
 - 10. Have you suffered with cancer of the womb?.....
 - 11. Have you had pharmaceutical hormone replacement therapy?
 - 12. Do you have an annual physical examination by a doctor?
 - 13. Do you perform a monthly breast self exam?
 - 14. Please estimate how many mammograms you have had total? _____ And age of 1st mammogram? _____
 - 15. How many births have you had? _____ Your age at birth of first child: _____
 - 16. Did your periods start before the age of 12? _____ Have your periods ended after the age of 50? _____
 - 17. Do you currently have a regular monthly period?.....
 - 18. Have you had a hysterectomy? No Partial Complete Age when you had hysterectomy? _____
 - 19. Do you smoke? Yes Never Not in the last year Not in last 5 years
- | | | |
|---|--------------------------|--------------------------|
| Have you recently had any of these breast symptoms: | RIGHT BREAST | LEFT BREAST |
| PAIN..... | <input type="checkbox"/> | <input type="checkbox"/> |
| TENDERNESS | <input type="checkbox"/> | <input type="checkbox"/> |
| LUMPS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| CHANGE IN BREAST SIZE..... | <input type="checkbox"/> | <input type="checkbox"/> |
| AREAS OF SKIN THICKENING OR DIMPLING | <input type="checkbox"/> | <input type="checkbox"/> |
| SECRETIONS OF THE NIPPLE | <input type="checkbox"/> | <input type="checkbox"/> |

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 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 _____