

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

- | <p>1. Have you recently had any of these breast symptoms? (mark only if "yes")</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">LT</th> <th style="width: 20%; text-align: center;">RT</th> </tr> </thead> <tbody> <tr> <td>Pain/Tenderness</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Lumps</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Change in breast size</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Areas of skin changes thickening or dimpling</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Excretions or changes of the nipple</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> <p>2. Are any of the above symptoms cycle related? <input type="radio"/> Yes <input type="radio"/> No</p> <p>3. Are you still having your periods? <input type="radio"/> Yes <input type="radio"/> No
 If yes, date of last period _____</p> <p>4. Have you had a surgical hysterectomy? <input type="radio"/> Yes <input type="radio"/> No
 If yes, date _____ <input type="radio"/> Complete <input type="radio"/> Partial
 Reason for hysterectomy?
 <input type="radio"/> Excess bleeding <input type="radio"/> Endometriosis <input type="radio"/> Fibroid cysts <input type="radio"/> Cancer <input type="radio"/> Other</p> <p>5. Has anyone in your family ever been treated for breast cancer? <input type="radio"/> Yes <input type="radio"/> No
 If yes, note age and survival <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter
 Age diagnosed _____ Result of Treatment _____</p> <p>6. Have you ever been diagnosed with breast cancer? <input type="radio"/> Yes <input type="radio"/> No
 If yes, date <u>Month</u> _____ <u>Year</u> _____
 Cancer type <input type="radio"/> Local <input type="radio"/> Metastatic <input type="radio"/> Lymph node involvement
 Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple
 Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple
 Treatment <input type="radio"/> Surgery <input type="radio"/> Chemo <input type="radio"/> Radiation <input type="radio"/> None</p> <p>7. Have you ever been diagnosed with any other breast disease? <input type="radio"/> Yes <input type="radio"/> No
 If yes, <input type="radio"/> Cysts/fibrocystic <input type="radio"/> Fibro Adenoma <input type="radio"/> Mastitis/inflammatory breast disease</p> <p>8. Have you had any cosmetic breast surgery or implants? <input type="radio"/> Yes <input type="radio"/> No
 If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline
 Experience: <input type="radio"/> Problems <input type="radio"/> No problems</p> | | 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"/> | |
|--|-----------------------|-----------------------|-----------|-----------------|-----------------------|-----------------------|-------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--|-----------------------|-----------------------|-------------------------------------|-----------------------|-----------------------|--|
| | 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"/> | | | | | | | | | | | | | | | | | |

- | | |
|-----|----|
| Yes | No |
|-----|----|
9. Have you ever had any biopsies or any other surgeries to your breasts
 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?
 If yes, Currently Less than 5 years More than 5 years
 11. Have you had pharmaceutical hormone replacement therapy (HRT)?
 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. Total mammograms _____
 17. Date of last mammogram _____ Were you re-called?
 18. Your age at your first mammogram? _____
 19. Number of full term pregnancies? _____
 20. Have you had breast ultrasound?
 If yes...Date: ____ / ____ Left ____ Right ____ Results: Negative ____ Positive ____
 21. Have you had breast MRI?
 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 _____