

Confidential Questionnaire

Women's Health Screening with Abdomen

Name _____ Birth Date _____ Today's Date _____
 Address _____ City _____ State _____ Zip _____
 Phone Number (home) _____ (cellular) _____ (work) _____
 Email _____ 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? | ___ | ___ |
| If yes, once a month or less ___ more than once a month ___ | | |
| 2. Do you have known allergies? Food ___ Environmental ___ | ___ | ___ |
| 3. Do you have TMJ or does your jaw click? | ___ | ___ |
| 4. Do you currently have a cold? | ___ | ___ |
| 5. Are you being treated for a thyroid disorder? Type _____ | ___ | ___ |
| 6. Do you have neck pain? | ___ | ___ |
| 7. Do you have upper back pain? | ___ | ___ |
| 8. Do you have a known history of carotid artery disease? | ___ | ___ |
| 9. Do you have a family history of stroke? | ___ | ___ |
| 10. Do you currently suffer with sinus problems? | ___ | ___ |
| 11. Do you have history of dental problems? | ___ | ___ |
| Root canals ___ Gum disease ___ Implants ___ | | |
| Non-replaced extractions ___ Dentures ___ | | |
| 12. Have you had dental cleaning in the past 7 days? | ___ | ___ |

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? (mark only if "yes")		___	___
	LT		RT
Pain/Tenderness	___		___
Lumps	___		___
Change in breast size	___		___
Areas of skin changes thickening or dimpling	___		___
Excretions or changes of the nipple	___		___
2. Are any of the above symptoms cycle related?		___	___
3. Are you still having your periods?		___	___
4. Have you had a surgical hysterectomy?		___	___
If yes, date _____ Complete ___ 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			
5. Has anyone in your family ever been treated for breast cancer?		___	___
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 _____			
6. Have you ever been diagnosed with breast cancer?		___	___
If yes, date: _Month _____ Year _____			
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			
7. Have you ever been diagnosed with any other breast disease?		___	___
If yes: Cysts/fibrocystic ___ Fibro Adenoma ___			
Mastitis/inflammatory breast disease ___			
8. Have you had any cosmetic breast surgery or implants?		___	___
If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline			
Experience: <input type="radio"/> Problems <input type="radio"/> No problems			

Abdomen & Lower Back

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

Have you consumed alcohol in the past 24 hours?

Yes___ No___

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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_____