Confidential Questionnaire

Women's Health Study 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.

Head & Neck

	Yes	No
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 ____ Dentures ____ Implants ____		
Non-replaced extractions ____ Gum Disease ____		
12. Have you had dental cleaning in the past 7 days?	___	___
13: Have you been diagnosed with elevated cholesterol?	___	___

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?

○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? ___ ___

If yes, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter

Age diagnosed _____ Result of Treatment_____

6. Have you ever been diagnosed with breast cancer? ___ ___

If yes, date: Month _____ Year _____

Cancer type ○ Local ○ Metastatic ○ Lymph node involvement

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? ___ ___

If yes: Cysts/fibrocystic ___ Fibro Adenoma ___

Mastitis/inflammatory breast disease ___

8. Have you had any cosmetic breast surgery _____or implants? ___ ___

If yes, date_____ if implants: ○ Silicone ○ Saline

Experience: ○ Problems ○ No problems

	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 ___		

Chest, Heart & Lungs

1. Have you been diagnosed with:	Yes	No
Heart disease?	___	___
Lung disease?	___	___
Upper spine disorders?	___	___

2. Do you suffer with upper back pain? ___ ___
3. Do you suffer with chest pain? ___ ___
4. Have you ever had surgery to your:
   - Heart? ___ ___
   - Lungs? ___ ___
   - Mid to upper back? ___ ___
5. Do you have asthma or shortness of breath? ___ ___
6. Do you currently smoke? ___ ___
7. Have you smoked in the past 5 years? ___ ___

Abdomen & Lower Back

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

Have you consumed alcohol in the past 24 hours? Yes___ No___

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_____