Confidential Questionnaire

Women's Health Screening with Abdomen

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cellular)_____(work)_____

E-Mail Address_____ Referring 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? ○ Do you grind your teeth? (Check all that apply)	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder? Type_____ What type of medication or supplement are you taking for Thyroid?_____	○	○
6. Do you have neck pain? ○ All the time ○ Occasional	○	○
7. Do you have upper back pain? ○ All the time ○ Occasional	○	○
8. Do you have a known history of carotid artery disease?	○	○
9. Do you have a family history of stroke? ○ Mom ○ Dad ○ Sibling ○ Grandparent (Maternal/Paternal)	○	○
10. Do you currently suffer with sinus problems? ○ Seasonal ○ All the time	○	○
11. Do you have history of dental problems? Root canals ____ Gum disease ____ Implants ____ Upper/Lower- Right/Left Upper/Lower- Right/Left Non-replaced extractions ____ Dentures _____ Upper/Lower- Right/Left	○	○
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? ○ ○
   If yes, date of last period_____

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_____
   _____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
   Notes:_____
   _____

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_____ ○ 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

NOTES:_____

10. Have you ever taken contraceptive pills for more than one year?	○	○

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

Total overall years taken_____

11. Have you had pharmaceutical hormone replacement therapy (HRT/Bio Identical)?	○	○

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

Name/Type of HRT? _____ Dates started/stopped _____

Name/Type Bio-Identical_____ Dates started/stopped _____

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?	○	○

Total time smoked?_____

15. Have you ever been diagnosed with diabetes?	○	○

When_____ List diabetes medication_____

16. Total mammograms____

17. Date of last mammogram _____ Were you re-called?	○	○

Did you go? _____

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 ____

NOTES:

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	○	○
List disease _____ Date of Diagnoses _____		
Lung disease?	○	○
List disease _____ Date of Diagnoses _____		
Upper spine disorders?	○	○
List type of disorder _____ Date Diagnosed _____		
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
Details/Location _____		
4. Have you ever had surgery to your:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
List type of surgery and date _____		
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 any 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? ○ ○

*List abdomen & Lower back surgery or disease information.
*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_____