



# 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.*

**Yes No**

### Head & Neck

1. Do you suffer with headaches?  Yes  No  
 If yes,  once a month or less  **more** than once a month
2. Do you have known allergies? Food \_\_\_\_ Environmental \_\_\_\_  Yes  No
3. Do you have TMJ or does your jaw click?  Yes  No
4. Do you currently have a cold?  Yes  No
5. Are you being treated for a thyroid disorder? Type \_\_\_\_\_  Yes  No
6. Do you have neck pain?  Yes  No
7. Do you have upper back pain?  Yes  No
8. Do you have a known history of carotid artery disease?  Yes  No
9. Do you have a family history of stroke?  Yes  No
10. Do you currently suffer with sinus problems?  Yes  No

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?  Yes  No

	<b>LT</b>	<b>RT</b>
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 thickening or dimpling	<input type="radio"/>	<input type="radio"/>		
Excretions of the nipple	<input type="radio"/>	<input type="radio"/>		
			<b>Yes</b>	<b>No</b>
2. Are any of the above symptoms cycle related?	<input type="radio"/>	<input type="radio"/>		
3. Are you still having periods?	<input type="radio"/>	<input type="radio"/>		
If yes, date of last period _____				
4. Have you had a surgical hysterectomy?	<input type="radio"/>	<input type="radio"/>		
If yes, date _____	<input type="radio"/>	<input type="radio"/>		
Complete				
Partial				
Reason for hysterectomy:				
Excess bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endometriosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fibroid cysts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other _____				
5. Has anyone in your family ever been treated for breast cancer?	<input type="radio"/>	<input type="radio"/>		
If yes,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mother				
Grandmother				
Sister				
Daughter				
Age diagnosed _____				
Result of Treatment _____				
6. Have you ever been diagnosed with breast cancer?	<input type="radio"/>	<input type="radio"/>		
If yes, date _____				
Cancer type	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Local				
Metastatic				
Lymph node involvement				
Left breast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inner				
Outer				
Nipple				
Right breast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inner				
Outer				
Nipple				
Treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Surgery				
Chemo				
Radiation				
None				
7. Have you ever been diagnosed with any other breast disease?	<input type="radio"/>	<input type="radio"/>		
If yes,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cysts/fibrocystic				
Fibro Adenoma				
Mastitis/inflammatory breast disease				
8. Have you had any cosmetic breast surgery or implants?	<input type="radio"/>	<input type="radio"/>		
If yes, date _____	<input type="radio"/>	<input type="radio"/>		
Silicone				
Saline				
Experience	<input type="radio"/>	<input type="radio"/>		
Problems				
No problems				
9. Have you ever had any biopsies or any other surgeries to your breasts?	<input type="radio"/>	<input type="radio"/>		
If yes, date _____				
Left breast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inner				
Outer				
Nipple				
Right breast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inner				
Outer				
Nipple				
Results	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Negative				
Positive				
Calcifications				
10. Have you ever taken contraceptive pills for more than one year?	<input type="radio"/>	<input type="radio"/>		
If yes,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Currently				
Less than 5 years				
More than 5 years				
11. Have you had pharmaceutical hormone replacement therapy (HRT)?	<input type="radio"/>	<input type="radio"/>		
If yes,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Currently				
Less than 5 years				
More than 5 years				
12. Do you have an annual physical examination by a doctor?	<input type="radio"/>	<input type="radio"/>		
13. Do you perform a monthly breast self exam?	<input type="radio"/>	<input type="radio"/>		
14. Have you ever smoked?	<input type="radio"/>	<input type="radio"/>		
15. Have you ever been diagnosed with diabetes?	<input type="radio"/>	<input type="radio"/>		
16. Total Mammograms _____				

17. Date of your last mammogram \_\_\_\_\_ Were you re-called?
18. Your age at your first mammogram? \_\_\_\_\_
19. Number of full term pregnancies? \_\_\_\_\_
20. Your age at birth of your first child? \_\_\_\_\_
21. Age when you started your period? \_\_\_\_\_

## ***Chest, Heart & Lungs***

- |   | <b>Yes</b>            | <b>No</b>             |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with:              |                       |                       |
| Heart disease?                                | <input type="radio"/> | <input type="radio"/> |
| Lung disease?                                 | <input type="radio"/> | <input type="radio"/> |
| Upper spine disorders?                        | <input type="radio"/> | <input type="radio"/> |
| 2. Do you suffer with upper back pain?        | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain?             | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had surgery to your:         |                       |                       |
| Heart?  | <input type="radio"/> | <input type="radio"/> |
| Lungs?  | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back?                            | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you currently smoke?                    | <input type="radio"/> | <input type="radio"/> |
| 7. Have you smoked in the past 5 years?       | <input type="radio"/> | <input type="radio"/> |

## ***Abdomen & Lower Back***

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Do you suffer with acid reflux?	<input type="radio"/>	<input type="radio"/>	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	<input type="radio"/>	<input type="radio"/>
Stomach?	<input type="radio"/>	<input type="radio"/>	Spleen(Upper Left) ?	<input type="radio"/>	<input type="radio"/>
Below R Breast?	<input type="radio"/>	<input type="radio"/>	Liver(Upper Right) ?	<input type="radio"/>	<input type="radio"/>
Below L Breast?	<input type="radio"/>	<input type="radio"/>	Kidneys ?	<input type="radio"/>	<input type="radio"/>
Abdomen?	<input type="radio"/>	<input type="radio"/>	Intestines ?	<input type="radio"/>	<input type="radio"/>
Lower Back?	<input type="radio"/>	<input type="radio"/>	Abdomen ?	<input type="radio"/>	<input type="radio"/>
Pelvic Region?	<input type="radio"/>	<input type="radio"/>	Lower Back?	<input type="radio"/>	<input type="radio"/>
			Pelvic Region?	<input type="radio"/>	<input type="radio"/>

Have you consumed alcohol in the past 24 hours?

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 \_\_\_\_\_