Confidential Questionnaire

Women's Comprehensive Full Body

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?	○	○
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?	○	○

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?	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○

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Areas of skin thickening or dimpling	○	○
Excretions of the nipple	○	○

	Yes	No
2. Are any of the above symptoms cycle related?	○	○
3. Are you still having 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, ○ Mother ○ Grandmother ○ Sister ○ Daughter

Age diagnosed _____ Result of Treatment_____

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

If yes, date_____

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_____ ○ Silicone ○ Saline

Experience ○ Problems ○ No problems

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 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

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?	○	○	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? ○ ○

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	LT	RT	2. Have you had Surgery to:	LT	RT
Leg?	○	○	Leg?	○	○
Sciatica?	○	○	Sciatica?	○	○
Buttocks/Hip?	○	○	Buttocks/Hip?	○	○
Knees?	○	○	Knees?	○	○
Ankles?	○	○	Ankles?	○	○
Feet?	○	○	Feet?	○	○

Do you have any special concerns or are there any details related to the information above?

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Shoulder?	○	○	Shoulder?	○	○
Elbow?	○	○	Elbow?	○	○
Arm?	○	○	Arm?	○	○
Hands?	○	○	Hands?	○	○

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_____

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