Breast Thermography Confidential Questionnaire

Name:____**Birthdate:**_______________

Address:______________________________**City:**_____________________**Zip:**________

Email:_____________________________**Phone:**_____________**Doctor:**_____________

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.

Please Mark Yes Or No As It Applies To You:	Yes	No
Do you have any close relative who has had breast cancer?		
Have you ever been diagnosed with breast cancer?		
Have you ever been diagnosed with any other breast disease (fibrocystic)?		
Have you had any biopsies or surgeries to your breasts?		
Have you had any breast cosmetic surgery or implants?		
Have you had a mammogram in the past 12 months?		
Have you had a mammogram in the past 5 years?		
Have you had abnormal results from any breast testing?		
Have you ever taken a contraceptive pill for more than a year?		
Have you suffered with cancer of the womb?		
Have you had pharmaceutical hormone replacement therapy?		
Do you have an annual physical examination by a doctor?		
Do you perform a monthly breast self exam?		

How many mammograms have you had in total? ___________
What was your age when you had your first mammogram?__________
How many births have you had?_______ Your age at the birth of your first child:_______
Did your period start before the age of 12?_______ Or finish after the age of 50?________
Do you smoke? Yes____ Never____ Not in the last 12 months____ Not in the last 5 years____
Had a vaccination in last 4 weeks? Indicate which arm: Left ___ Right ___ No ____

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Have you **recently** had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	**Right Breast**	**Left Breast**
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

PATIENT DISCLOSURE:

I understand that the Report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will **not** tell me whether I have any illness, disease, or other condition 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 statements above and consent to the examination.

Signature ____ Date________________