Confidential Questionnaire

Women's Health Study

Name______________________________________ Birth Date_________ Today's Date_____________

Address____________________________________ City______________ State_______ Zip_________

Phone Number (home)__________________(cellular)________________(work)___________________

E-Mail 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? ___ ___

   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 ____ Gum disease ____ Implants ____

    Non-replaced extractions ____ Dentures ____

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? ___ ___
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____________________ ○ 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? ___ ___

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.*

Client 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.

Client Signature____Today's Date____________