

Patient's Name

D.O.B.



Confidential Questionnaire – Women's Breast Questionnaire

Report Date

Referring Physician

Address	City					
Province	Postal Code	Postal Code Cellular Phone				
Home Phone	Cellular Phone					
Work Phone	ork Phone E-Mail					
_	questionnaire will remain strictly confidential and thermologist and any other practitioner that you	-				
	YES	NO				
Are you currently taking any su	pplements; if yes please list					
Are you currently taking any me	edication; if yes please list					
Are you using bio identical horn	nones?					
Progesterone						
Estrogen						
DHEA						
Testosterone						

BREAST

Is there a specific reason or concern for this breast exam?

				YES	NO
Have you recently had any of thes	e breast sympto	ms?			
		LT R	T		
Pain/Tenderness					
Lumps					
Change in breast size					
Areas of skin thickening or dimpling					
Excretions of the nipple					
Are any of the above symptoms re	elated to your cy	cle?			
Are you still having periods?					
If Yes, date of last period					
Have you had a surgical Hysterect	omy2				
		5			
If Yes, Date Complete Partial					
Reason for Hysterectomy?					
Excess bleeding Endon	netrosis Fi	broid Cysts	Car	ncer O	ther
Has anyone in your family ever been treated for breast cancer?					
If Yes, Mother G	irandmother	Sister	Daugh	ter	
If Yes, Age diagnosed		Surv	vived:		
Have you ever been diagnosed with breast cancer?					
If Yes, Date					1
Cancer type Local	Metasta	tic	Lymph n	ode involvem	ent
Left breast Inner	Outer		Nipple		
Right breast Inner	Outer		Nipple		
Treatment Surgery	Chemo		Radiation	1	None
Have you ever been diagnosed with any other breast disease?					
If Yes, Cysts/fibrocystic Mastitis/inflammatory breast disea		st diseas	e Fibro	Adenoma	

Have you ever had	d any cosmetic k	oreast surgery or	implant	ts?		
If yes, Date			-			
Type:	_	cone Sali	_			
Exper	ience: Pro	oblems No	Probler	ns		
Have you ever had any biopsies or other surgeries to your breasts?						
If yes, Date						
Left breast	Inner	(Outer		Nipple	
Right breast	Inner	(Outer		Nipple	
Results	Negativ	ve F	Positive		Calcifications	
Have you ever tak	en contraceptiv	e pills for more th	han one	e year?		
If Yes,	Currently	Less than 5 year	rs	More than 5	years	
Have you ever had pharmaceutical hormone replacement therapy (HRT)?						
If Yes,	Currently	Less than 5 year	S	More than 5	years	
Do you have an ar	nual physical ex	kamination by a c	doctor?			
Do you perform a monthly breast self-exam?						
Have you ever smoked?						
Have you ever been diagnosed with diabetes?						
Date of value last was reasons						
Date of your last mammogram						
Were you re-called?						
How many mammograms have you had in total?						
Your age at your first mammogram?						
Number of full term pregnancies?						
Your age at birth of your first child?						
Age when you started your period?						

Do you have any special concerns or 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 understand that the report will not tell me whether, I have any illness, diseases, or ot conditions, but will be an analysis of the images with respect only to the thermograp findings discussed in the report.				
By signing below, I certify that I have related the examination.	ad and understand the statement above and consent to			
Patient Signature	Today's Date			