Thermography Medical Clinic

The Future of Preventative Healthcare...Today!

Physicians INSIGHT Clinical Interpretation

Confidential Questionnaire – Women's Health Screening

Patient's Name	**Report Date**
D.O.B.	**Referring Physician**
Address	**City**
Province	**Postal Code**
Home Phone	**Cellular Phone**
Work Phone	**E-Mail**

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**
Are you currently taking any supplements; if yes please list		
Are you currently taking any medication; if yes please list		
Are you using bio identical hormones?		
Progesterone		
Estrogen		
DHEA		
Testosterone		

HEAD & NECK

Question	YES	NO
Do you suffer with headaches?		
If yes, once a month or less more than once a month		
Do you have allergies?		
Do you have TMJ or does your jaw click?		
Do you currently have a cold?		
Are you being treated for a thyroid disorder?		
Do you have neck pain?		
Do you have upper back pain?		
Do you have a history of carotid artery disease?		
Do you have a family history of stroke?		
Do you currently suffer with sinus problems?		

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

BREAST

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

	YES	NO
Have you recently had any of these breast symptoms? LT RT Pain/Tenderness Lumps Change in breast size Areas of skin thickening or dimpling Excretions of the nipple		
Are any of the above symptoms related to your cycle?		
Are you still having periods?		
If Yes, date of last period		
Have you had a surgical Hysterectomy?		
If Yes, Date Complete Partial		
Reason for Hysterectomy?		
Excess bleeding Endometrosis Fibroid Cysts Cancer Other		
Has anyone in your family ever been treated for breast cancer?		
If Yes, Mother Grandmother Sister Daughter		
If Yes, Age diagnosed Survived:		
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		
Have you ever been diagnosed with any other breast disease?		
If Yes, Cysts/fibrocystic Mastitis/inflammatory breast disease Fibro Adenoma		
Have you ever had any cosmetic breast surgery or implants?		

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If yes, Date Type: Silicone Saline Experience: Problems No Problems		
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 ○ Negative ○ Positive ○ Calcifications		
Have you ever taken contraceptive pills for more than one year?		
If Yes, Currently Less than 5 years More than 5 years		
Have you ever had pharmaceutical hormone replacement therapy (HRT)?		
If Yes, Currently Less than 5 years More than 5 years		
Do you have an annual physical examination by a doctor?		
Do you perform a monthly breast self-exam?		
Have you ever smoked?		
Have you ever been diagnosed with diabetes?		
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 details related to the information above?

CHEST, HEART, LUNGS

	YES	NO
Have you been diagnosed with		
Heart Disease		
Lung Disease		
Upper Spine Disorders		
Do you suffer with upper back pain?		
Do you suffer with chest pain?		
Have you ever had surgery to your:		
Heart		
Lungs		
Mid to upper back		
Do you have Asthma or shortness of breath?		
Do you currently smoke?		
Have you smoked in the past 5 years?		

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

ABDOMEN & LOWER BACK

ABDOMEN & LOWER BACK	YES	NO
Do you suffer with acid reflux?		
Do you have pain in:		
Stomach?		
Below the right breast?		
Below the left breast?		
Abdomen?		
Lower back?		
Have you had surgery or disease in the:		
Stomach?		
Spleen? Left upper quadrant		
Liver? Right upper quadrant		
Kidneys?		
Intestines?		
Abdomen?		
Lower Back?		

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. 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 ____________________