BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

Name: _____ Date of Birth:_____

Address: _____ City:_____ Zip: _____

Email: _____Phone: _____ Doctor: _____

1. Have you been diagnosed with Breast Cancer?
    - If yes when? _____
    - Cancer type? _____Metastatic ____ Local _____ Lymph Node involvement _____
    - Where (left breast) ___ upper/outer ___ upper/inner___lower/outer___lower/inner__ nipple
    - Where (right breast) ___upper/outer ___upper/inner___lower/outer ___lower/inner___ nipple
    - Treatment: ____None ___Surgery ___Chemotherapy ___Radiation
    - If breast radiation was treatment- date of last treatment? _____ left breast or right breast
    - Any other treatment? _____
    - Any breast reconstruction after mastectomy? _____
    - If yes, what type? (ex: trans flap, implant?) _____ left breast or right breast
2. Have you been diagnosed with any other breast disease (fibrocystic, cystic, mastitis, dense breast tissue, abscess or other)? _____
3. Have you had any biopsies, lumpectomies, or surgeries to your breasts? _____
    - If yes, Date? _____
    - Was the result Positive or Negative? _____
    - Left Breast or Right Breast? _____
    - Upper/Outer ____ Upper/Inner ____ Lower/Outer ____Lower/Inner ____ Nipple ____
4. Have you had any breast cosmetic surgery or implants (Implants, Reduction or Lift)? _____
5. Do you have any close relatives who has had breast cancer? _____
6. Have you had a Mammogram in the past 12 months? _____
    - Date? _____
    - Was it Normal, Abnormal, Suspicious, or inconclusive? _____Right or Left? _____
7. Have you had a Mammogram in the past 5 years? _____
    - Date?
    - Was it Normal, Abnormal, Suspicious, or inconclusive? _____ Right or Left? _____

8. Was follow up biopsy recommended after your recent mammogram, ultrasound, or Mri? _____
9. Have you had any abnormal results from any breast testing? _____

- If yes, briefly explain: _____

10. Do you perform a monthly breast exam? _____
11. Do you have an annual physical examination by a doctor? _____
12. What was your age when you had your first mammogram? _____
13. How many mammograms have you had in total? _____
14. Are you currently nursing? _____
15. Are you currently pregnant? _____
16. Have you had pharmaceutical hormone replacement therapy? _____

17. Have you used bio identical hormone? _____
    - If yes, what kind? _____ gel/cream _____ oral _____ pellet
18. Have you been diagnosed with ovarian, cervical or uterine Cancer? _____
    - If yes, when and what kind? _____
19. Have you had any of the following?
    - Hysterectomy? _____
    - Oophorectomy (ovaries)? _____
    - Total/ Radical hysterectomy (uterus+Ovaries+Tubes) _____
20. Have you ever had cancer of the womb? _____ If yes date? _____
21. Have you ever taken a contraceptive pill/patch for more than 1 year? _____
22. Did you start your period before the age of 12? _____
23. Did your periods finish after the age of 50? _____
24. Are you still having a monthly period? _____
25. How many births had you had? _____
26. What was your age when your first child was born? _____
27. Do you smoke? _____
28. Have you **Recently/Currently** experienced any of these symptoms?

    (If yes, please mark which breast)

	Left Breast	Right Breast
Pain?	_____	_____
Tenderness?	_____	_____
Lumps?	_____	_____
Change in breast size?	_____	_____
Areas of skin thickening/dimpling?	_____	_____
Secretions of the nipples?	_____	_____

If experiencing nipple discharge- is it Bloody? ____ Milky? _____ Clear? _____

If nipple retraction- How many years? ____ Recently? ____ Left or Right Breast or both? _____

PATIENT DISCLOSURE: I understand that the Report generated from my images is intended for my use by trained health care providers to assist in evaluation, diagnosis & 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 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 the consent to the examination.

_____ _____

Signature of Patient or Patient's Authorized Representative **Today's Date**