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.

Breast Thermography Confidential Questionnaire

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease?	☐	☐
4. Have you ever had any biopsies or surgeries to breasts?	☐	☐
5. Have you ever had any breast cosmetic surgery or implants?	☐	☐
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had any abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you ever suffered with cancer of the womb?	☐	☐
11. Have you ever had hormone replacement therapy?	☐	☐
12. Have you had an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

14. Total Mammograms?_____ 15. Age at first mammogram ?_____
16. Children given birth to? _____ 17. Age at birth of first child? _____
18. Age periods started? _____ 19. Age periods stopped? _____
20. Smoker? Yes____ Never ____ Not in last 12 months ____ Not in last 5 years ____

Recently had any of these breast symptoms:	Right Breast	Left Breast
21. Pain?	☐	☐
22. Tenderness?	☐	☐
23. Lumps?	☐	☐
24. Change in breast size?	☐	☐
25. Areas of skin thickening or dimpling?	☐	☐
26. Secretions of the nipple?	☐	☐

Diagnosed with breast cancer:

27. Cancer type: Metastatic _____ Local _____ Lymph node involvement _____
28. When diagnosed: Month _____ Year _____
29. Where (left breast): UO ___ UI ___ LO ___ LI ___ Nipple ___
30. Where (right breast): UO ___ UI ___ LO ___ LI ___ Nipple ___
31. Treatment: Surgery ___ Chemo ___ Radiation ___ Other___ None ___

Diagnosed with other breast disease:

32. Disease type: Fibrocystic ___ Cystic ___ Mastitis ___ Abscess ___ Other ___

Breast biopsies or surgery:

33. Where (left breast): UO ___ UI ___ LO ___ LI ___ Nipple ___
34. Where (right breast): UO ___ UI ___ LO ___ LI ___ Nipple ___

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care 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 _____ Today's Date _____