# Confidential Questionnaire

# *Breast*

Name_____Birth Date_____Today's Date_____
Address_____City_____State_____Zip_____
Phone Number Home_____Cellular_____Work_____
E-Mail Address_____
Referring Physician_____

Is there a specific reason or concern for this exam?

| | |
|---|---|
| | |

| | Yes | No |
|---|---|---|
| 1. 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 | ○ | ○ |

2. Are any of the above symptoms cycle related? ○ ○

3. Are you still having your periods? ○ ○
   If yes, date of last period_____

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

| | Y | N |
|---|---|---|
| 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. Your age at birth of your first child?_____ | | |
| 21. Age when you started your period?_____ | | |

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.*

***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_____



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