

# Confidential Questionnaire

## *Women's Health Screening with Abdomen*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number (home) \_\_\_\_\_ (cellular) \_\_\_\_\_ (work) \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Referring Physician \_\_\_\_\_

*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**

### *Head & Neck*

- |  |                       |                       |
|--|-----------------------|-----------------------|
| 1. Do you suffer with headaches?   | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="radio"/> once a month or less <input type="radio"/> <b>more</b> than once a month |                       |                       |
| 2. Do you have known allergies? Food _____ Environmental _____   | <input type="radio"/> | <input type="radio"/> |
| 3. Do you have TMJ or does your jaw click?   | <input type="radio"/> | <input type="radio"/> |
| 4. Do you currently have a cold?   | <input type="radio"/> | <input type="radio"/> |
| 5. Are you being treated for a thyroid disorder? Type _____  | <input type="radio"/> | <input type="radio"/> |
| 6. Do you have neck pain?  | <input type="radio"/> | <input type="radio"/> |
| 7. Do you have upper back pain?  | <input type="radio"/> | <input type="radio"/> |
| 8. Do you have a known history of carotid artery disease?  | <input type="radio"/> | <input type="radio"/> |
| 9. Do you have a family history of stroke?   | <input type="radio"/> | <input type="radio"/> |
| 10. Do you currently suffer with sinus problems?   | <input type="radio"/> | <input type="radio"/> |

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

### *Breast*

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

**Yes No**

- |  |                       |                       |
|--|-----------------------|-----------------------|
| 1. Have you recently had any of these breast symptoms? | <input type="radio"/> | <input type="radio"/> |
|  | <b>LT</b>             | <b>RT</b>             |
| Pain/Tenderness  | <input type="radio"/> | <input type="radio"/> |
| Lumps  | <input type="radio"/> | <input type="radio"/> |
| Change in breast size                                  | <input type="radio"/> | <input type="radio"/> |
| Areas of skin thickening or dimpling                   | <input type="radio"/> | <input type="radio"/> |
| Excretions of the nipple                               | <input type="radio"/> | <input type="radio"/> |

	<b>Yes</b>	<b>No</b>
2. Are any of the above symptoms cycle related?	<input type="radio"/>	<input type="radio"/>
3. Are you still having periods? If yes, date of last period _____	<input type="radio"/>	<input type="radio"/>
4. Have you had a surgical hysterectomy? If yes, date _____ <input type="radio"/> Complete <input type="radio"/> Partial Reason for hysterectomy: <input type="radio"/> Excess bleeding <input type="radio"/> Endometriosis <input type="radio"/> Fibroid cysts <input type="radio"/> Cancer <input type="radio"/> Other _____	<input type="radio"/>	<input type="radio"/>
5. Has anyone in your family ever been treated for breast cancer? If yes, <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter Age diagnosed _____ Result of Treatment _____	<input type="radio"/>	<input type="radio"/>
6. Have you ever been diagnosed with breast cancer? If yes, date _____ Cancer type <input type="radio"/> Local <input type="radio"/> Metastatic <input type="radio"/> Lymph node involvement Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple Treatment <input type="radio"/> Surgery <input type="radio"/> Chemo <input type="radio"/> Radiation <input type="radio"/> None	<input type="radio"/>	<input type="radio"/>
7. Have you ever been diagnosed with any other breast disease? If yes, <input type="radio"/> Cysts/fibrocystic <input type="radio"/> Fibro Adenoma <input type="radio"/> Mastitis/inflammatory breast disease	<input type="radio"/>	<input type="radio"/>
8. Have you had any cosmetic breast surgery or implants? If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline Experience <input type="radio"/> Problems <input type="radio"/> No problems	<input type="radio"/>	<input type="radio"/>
9. Have you ever had any biopsies or any other surgeries to your breasts? If yes, date _____ Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple Results <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Calcifications	<input type="radio"/>	<input type="radio"/>
10. Have you ever taken contraceptive pills for more than one year? If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years	<input type="radio"/>	<input type="radio"/>
11. Have you had pharmaceutical hormone replacement therapy (HRT)? If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years	<input type="radio"/>	<input type="radio"/>
12. Do you have an annual physical examination by a doctor?	<input type="radio"/>	<input type="radio"/>
13. Do you perform a monthly breast self exam?	<input type="radio"/>	<input type="radio"/>
14. Have you ever smoked?	<input type="radio"/>	<input type="radio"/>
15. Have you ever been diagnosed with diabetes?	<input type="radio"/>	<input type="radio"/>
16. Total Mammograms _____		
17. Date of your last mammogram _____ Were you re-called?	<input type="radio"/>	<input type="radio"/>

- 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? \_\_\_\_\_

## ***Chest, Heart & Lungs***

- |   | <b>Yes</b>            | <b>No</b>             |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with:              |                       |                       |
| Heart disease?                                | <input type="radio"/> | <input type="radio"/> |
| Lung disease?                                 | <input type="radio"/> | <input type="radio"/> |
| Upper spine disorders?                        | <input type="radio"/> | <input type="radio"/> |
| 2. Do you suffer with upper back pain?        | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain?             | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had surgery to your:         |                       |                       |
| Heart?  | <input type="radio"/> | <input type="radio"/> |
| Lungs?  | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back?                            | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you currently smoke?                    | <input type="radio"/> | <input type="radio"/> |
| 7. Have you smoked in the past 5 years?       | <input type="radio"/> | <input type="radio"/> |

## ***Abdomen & Lower Back***

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Do you suffer with acid reflux?	<input type="radio"/>	<input type="radio"/>	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	<input type="radio"/>	<input type="radio"/>
Stomach?	<input type="radio"/>	<input type="radio"/>	Spleen(Upper Left) ?	<input type="radio"/>	<input type="radio"/>
Below R Breast?	<input type="radio"/>	<input type="radio"/>	Liver(Upper Right) ?	<input type="radio"/>	<input type="radio"/>
Below L Breast?	<input type="radio"/>	<input type="radio"/>	Kidneys ?	<input type="radio"/>	<input type="radio"/>
Abdomen?	<input type="radio"/>	<input type="radio"/>	Intestines ?	<input type="radio"/>	<input type="radio"/>
Lower Back?	<input type="radio"/>	<input type="radio"/>	Abdomen ?	<input type="radio"/>	<input type="radio"/>
Pelvic Region?	<input type="radio"/>	<input type="radio"/>	Lower Back?	<input type="radio"/>	<input type="radio"/>
			Pelvic Region?	<input type="radio"/>	<input type="radio"/>

Have you consumed alcohol in the past 24 hours?

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 \_\_\_\_\_