



Confidential Questionnaire

Women's Health Screen

Name _____

Birth Date _____

Today's Date _____

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? Yes No
If yes, once a month or less more than once a month
2. Do you have known allergies? Food ____ Environmental ____ Yes No
3. Do you have TMJ, or does your jaw click? Yes No
4. Do you currently have a cold? Yes No
5. Are you being treated for a thyroid disorder? Type _____ Yes No
6. Do you have neck pain? Yes No
7. Do you have upper back pain? Yes No
8. Do you have a known history of carotid artery disease? Yes No
9. Do you have a family history of stroke? Yes No
10. Do you currently suffer from sinus problems? Yes No
11. Do you have a history of dental problems? Yes No
Root canals ____ Gum disease ____ Implants ____
Non-replaced extractions ____ Dentures ____
12. Have you had a dental cleaning in the past 7 days? Yes No

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"/> |
| | LT | RT |
| 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 changes thickening or dimpling | <input type="radio"/> | <input type="radio"/> |
| Excretions of the nipple | <input type="radio"/> | <input type="radio"/> |
| | Yes | No |
| 2. Are any of the above symptoms cycle-related? | <input type="radio"/> | <input type="radio"/> |
| 3. Are you still having periods? | <input type="radio"/> | <input type="radio"/> |
| If yes, date of last period _____ | | |
| 4. Have you had a surgical hysterectomy? | <input type="radio"/> | <input type="radio"/> |
| 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 _____ | | |
| 5. Has anyone in your family ever been treated for breast cancer? | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter | | |
| Age diagnosed _____ Result of Treatment _____ | | |
| 6. Have you ever been diagnosed with breast cancer? | <input type="radio"/> | <input type="radio"/> |
| 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 | | |
| 7. Have you ever been diagnosed with any other breast disease? | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="radio"/> Cysts/fibrocystic <input type="radio"/> Fibro Adenoma <input type="radio"/> Mastitis/inflammatory breast disease | | |

Chest, Heart & Lungs

- | | | |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with: | Yes | No |
| 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"/> |
| | Yes | No |
| 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

	Yes	No		Yes	No
1. Do you suffer from acid reflux or other digestive problems?	<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? Yes No

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