

Confidential Questionnaire

Women's Health Screen

Name	N	am	e
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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.

Head & Neck Do you suffer with headaches? If yes, ○ once a month or less ○ more than once a month Do you have known allergies? Food Environmental Do you have TMJ, or does your jaw click? Do you currently have a cold? Are you being treated for a thyroid disorder? Type Do you have neck pain? Do you have upper back pain? Do you have a known history of carotid artery disease? Do you have a family history of stroke?	0	Yes	No
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 Are you being treated for a thyroid disorder? Type Do you have neck pain? Do you have upper back pain? Do you have a known history of carotid artery disease? Do you have a family history of stroke? 		0	0
Do you have neck pain?Do you have upper back pain?Do you have a known history of carotid artery disease?Do you have a family history of stroke?		0	_
Do you have upper back pain?Do you have a known history of carotid artery disease?Do you have a family history of stroke?			0
Do you have a known history of carotid artery disease?Do you have a family history of stroke?		0	
Do you have a family history of stroke?			0
		0	0
		0	0
0. Do you currently suffer from sinus problems?		0	0
1. Do you have a history of dental problems?		0	0
Root canals Gum disease Implants			
Non-replaced extractions Dentures			
2. Have you had a dental cleaning in the past 7 days?		0	0
	,		
o you have any special concerns or are there any details related to the i	ntorma	ition ab	ove?

Breast

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

				Yes	No
1.	Have you recently had any of these breast symp	toms?		0	0
		LT	RT		
	Pain/Tenderness	0	0		
	Lumps	0	0		
	Change in breast size	0	0		
	Areas of skin changes thickening or dimpling	0	0		
	Excretions of the nipple	0	0	X 7	N T
				Yes	No
2.	Are any of the above symptoms cycle-related?			0	0
3.	Are you still having periods? If yes, date of last period			0	0
4.	Have you had a surgical hysterectomy?			0	0
	If yes, date Reason for hysterectomy:	Complete	O Partial		
	○ Excess bleeding ○ Endometriosis ○ Fibroid	cysts O Canc	er Other		
5.	Has anyone in your family ever been treated for	breast cancer?	•	0	0
	If yes, O Mother O Grandmother Age diagnosed Result of Treatment		_		
6.	Have you ever been diagnosed with breast cancer			0	0
	If yes, date:				
	Cancer type O Local O Metastat	cic O Ly	mph node invol	vement	
	Left breast O Inner Outer	o Ni	pple		
	Right breast O Inner O Outer	o Ni	pple		
	Treatment O Surgery O Chemo		diation	None	
7.	Have you ever been diagnosed with any other be	reast disease?		0	0
	If yes, O Cysts/fibrocystic O Fibro Ade	noma O Mas	titis/inflammato	ory breast disea	ise

		Yes	No
8. Have you had	d any cosmetic breast surgery or implants?	0	0
If yes, date_	O Silicone O Saline		
Experience	○ Problems ○ No problems		
-	er had any biopsies or any other surgeries to your breasts?	0	0
Left breast	InnerOuterNipple		
_	 Inner Outer Nipple Negative Positive Calcifications 		
10. Have you evil If yes,	ver taken contraceptive pills for more than one year? • Currently • Less than 5 years • More than 5 years	0	0
11. Have you ha	ad pharmaceutical hormone replacement therapy (HRT)? • Currently • Less than 5 years • More than 5 years	0	0
12. Do you hav	e an annual physical examination by a doctor?	0	0
13. Do you perf	form a monthly breast self-exam?	0	0
14. Have you ev	ver smoked?	0	0
15. Have you ev	ver been diagnosed with diabetes?	0	0
16. Total Mamm	nograms		
17. Date of you	ır last mammogram Were you re-called?	0	0
18. Your age at	your first mammogram?		
19. Number of	full-term pregnancies?		
•	ad breast ultrasound? te:/ Left Right Results: Negative Positive	0	0
21. Have you hat If yesDat	ad breast MRI? te:/ Left Right Results: Negative Positive _	0	0

Chest, Heart & Lungs

1. Have you been diagnosed with:		Yes	No
Heart disease?		0	0
Lung disease?		0	0
Upper spine diso	rders?	Ο	0
2. Do you suffer with upper back pain?			
3. Do you suffer with chest pain?4. Have you ever had surgery to your:		0	Ο
Heart?		0	0
Lungs?		0	Ο
Mid to upper bac	k?	0	0
5. Do you have asthma or shortness of breath?		0	0
		Yes	No
6. Do you currently smoke?		0	0
7. Have you smoked in the past 5 years?		Ο	Ο

Abdomen & Lower Back

_	Yes	No		Yes	No
 Do you suffer from acid reflu 	x or oth	ner	Have you had surgery or disease i	n the:	
digestive problems?	0	0			
2. Do you suffer pain in the:			Stomach?	0	0
Stomach?	0	0	Spleen(Upper Left)?	0	0
Below R Breast?	0	0	Liver(Upper Right)?	0	0
Below L Breast?	0	0	Kidneys?	0	0
Abdomen?	0	0	Intestines?	0	0
Lower Back?	0	0	Abdomen?	0	0
Pelvic Region?	0	0	Lower Back?	0	0
		<u>'</u>	Pelvic Region?	0	0

Have you consumed alcohol in the past 24 hours?	
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Do you have any special concerns or are there any details related to the information above?