

Confidential Questionnaire *Women's* *Health Study with Abdomen*

Name _____ Birth Date _____ Today's Date _____
 Address _____ City _____ State _____ Zip _____
 Phone Number (home) _____ (cellular) _____ (work) _____
 Email _____ 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
<i>Head & Neck</i>		
1. Do you suffer with headaches? If yes, once a month or less ____ more than once a month ____	___	___
2. Do you have known allergies? Food ____ Environmental ____	___	___
3. Do you have TMJ or does your jaw click?	___	___
4. Do you currently have a cold?	___	___
5. Are you being treated for a thyroid disorder? Type _____	___	___
6. Do you have neck pain?	___	___
7. Do you have upper back pain?	___	___
8. Do you have a known history of carotid artery disease?	___	___
9. Do you have a family history of stroke?	___	___
10. Do you currently suffer with sinus problems?	___	___
11. Do you have history of dental problems? Root canals ____ Gum disease ____ Implants ____ Non-replaced extractions ____ Dentures ____	___	___
12. Have you had dental cleaning in the past 7 days?	___	___

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? (mark only if "yes")	___	___																								
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 10%; text-align: center;">LT</th> <th style="width: 10%; text-align: center;">RT</th> <th style="width: 40%;"></th> </tr> </thead> <tbody> <tr> <td>Pain/Tenderness</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Lumps</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Change in breast size</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Areas of skin changes thickening or dimpling</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Excretions or changes of the nipple</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> </tbody> </table>		LT	RT		Pain/Tenderness	___	___		Lumps	___	___		Change in breast size	___	___		Areas of skin changes thickening or dimpling	___	___		Excretions or changes of the nipple	___	___			
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2. Are any of the above symptoms cycle related?	___	___																								
3. Are you still having your periods?	___	___																								
4. Have you had a surgical hysterectomy?	___	___																								
If yes, date _____ Complete ___ 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?	___	___																								
If yes, note age and survival <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?	___	___																								
If yes, date: _Month _____ Year _____																										
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?	___	___																								
If yes: Cysts/fibrocystic ___ Fibro Adenoma ___																										
Mastitis/inflammatory breast disease ___																										
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																										

	Yes	No
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		
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	___	___
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	___	___
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. Have you had breast ultrasound? If yes...Date: ___/___/___ Left ___ Right ___ Results: Negative ___ Positive ___	___	___
21. Have you had breast MRI? If yes...Date: ___/___/___ Left ___ Right ___ Results: Negative ___ Positive ___	___	___

Chest, Heart & Lungs

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

Abdomen & Lower Back

Yes No		Yes No	
1. Do you suffer with acid reflux or other digestive problems? Yes___ No___		Have you had surgery or disease in the:	
2. Do you suffer pain in the:		Stomach?	Yes___ No___
Stomach?	Yes___ No___	Spleen(Upper Left) ?	Yes___ No___
Below R Breast?	Yes___ No___	Liver(Upper Right) ?	Yes___ No___
Below L Breast?	Yes___ No___	Kidneys ?	Yes___ No___
Abdomen?	Yes___ No___	Intestines ?	Yes___ No___
Lower Back?	Yes___ No___	Abdomen ?	Yes___ No___
Pelvic Region?	Yes___ No___	Lower Back?	Yes___ No___
		Pelvic Region?	Yes___ No___

Have you consumed alcohol in the past 24 hours?

Yes___ No___

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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.

Client 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.

Client Signature _____ Today's Date _____