

Confidential Questionnaire

Women's Comprehensive Full Body

Name _____ Birth Date _____ Today's Date _____
 Address _____ City _____ State _____ Zip _____
 Phone Number (home) _____ (cellular) _____ (work) _____
 Email _____ Physician's Name _____

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”)	___	___
	LT	RT
Pain/Tenderness	___	___
Lumps	___	___
Change in breast size	___	___
Areas of skin changes thickening or dimpling	___	___
Excretions or changes of the nipple	___	___
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		

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___

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	2. Have you had Surgery to:
Leg? LT___ RT___	Leg? LT___ RT___
Sciatica LT___ RT___	Sciatica? LT___ RT___
Buttocks/Hip? LT___ RT___	Buttocks/Hip? LT___ RT___
Knees? LT___ RT___	Knees? LT___ RT___
Ankles? LT___ RT___	Ankles? LT___ RT___
Feet? LT___ RT___	Feet? LT___ RT___

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	LT	RT	2. Have you had surgery to:	LT	RT
Shoulder?	___	___	Shoulder?	___	___
Elbow?	___	___	Elbow?	___	___
Arm?	___	___	Arm?	___	___
Hands?	___	___	Hands?	___	___

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 _____