Confidential Questionnaire

Women's Health Study

Name______________________________________ Birth Date_________ Today's Date_____________

Address____________________________________ City______________ State_______ Zip_________

Phone Number (home)_________________(cellular)________________(work)__________________

E-Mail 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

Question	Yes	No
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	____	____

	Yes	No
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:

○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

	Yes	No
5. Has anyone in your family ever been treated for breast cancer?	___	___

If yes, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter

Age diagnosed ________ Result of Treatment__________________________________

	Yes	No
6. Have you ever been diagnosed with breast cancer?	___	___

If yes, date: _Month ________Year_________

Cancer type	○ Local	○ Metastatic	○ Lymph node involvement	
Left breast	○ Inner	○ Outer	○ Nipple	
Right breast	○ Inner	○ Outer	○ Nipple	
Treatment	○ Surgery	○ Chemo	○ Radiation	○ None

	Yes	No
7. Have you ever been diagnosed with any other breast disease?	___	___

If yes: Cysts/fibrocystic ___ Fibro Adenoma ___

Mastitis/inflammatory breast disease ___

	Yes	No
8. Have you had any cosmetic breast surgery or implants?	___	___

If yes, date___________________ ○ Silicone ○ Saline

Experience: ○ Problems ○ No problems

Yes No

9. Have you ever had any biopsies or any other surgeries to your breasts ___ ___
   If yes, date___________________
   Left breast ○ Inner ○ Outer ○ Nipple
   Right breast ○ Inner ○ Outer ○ Nipple
   Results ○ Negative ○ Positive ○ Calcifications

10. Have you ever taken contraceptive pills for more than one year? ___ ___
    If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

11. Have you had pharmaceutical hormone replacement therapy (HRT)? ___ ___
    If yes, ○ Currently ○ Less than 5 years ○ 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

1. Have you been diagnosed with: **Yes No**
   - 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? ___ ___

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.*

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_____________