## **Breast Thermography Confidential Questionnaire**

Name:	Birthdate:				
Address:	City:		Zip:		
Email:	Phone:	Doctor:_			
All information given in the questionna mologist and any other practitioner tha	-	d will only be divulged	to the report	ling ther-	
Please Mark	Yes Or No As It Applies To Y	'ou:	Yes	No	
Do you have any close relative	who has had breast cancer?				
Have you ever been diagnosed	d with breast cancer?				
Have you ever been diagnosed	d with any other breast disease	(fibrocystic)?			
Have you had any biopsies or	surgeries to your breasts?				
Have you had any breast cosm	netic surgery or implants?				
Have you had a mammogram	in the past 12 months?				
Have you had a mammogram	in the past 5 years?				
Have you had abnormal results	s from any breast testing?				
Have you ever taken a contrac	eptive pill for more than a year	?			
Have you suffered with cancer	of the womb?				
Have you had pharmaceutical	hormone replacement therapy'	?			
Do you have an annual physic	al examination by a doctor?				
Do you perform a monthly brea	ast self exam?				
How many mammograms have	you had in total?	_			
What was your age when you h	nad your first mammogram?				
How many births have you had	? Your age at the birtl				
Did your period start before the	age of 12? Or finish a	after the age of 50	)?	_	
Do you smoke? Yes Neve	r Not in the last 12 month	s Not in the I	ast 5 years	3	
Had a vaccination in last 4 wee	eks? Indicate which arm: Left	Right No		_	

## **Breast Thermography Confidential Questionnaire**

Have you recently had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	Right Breast	Left Breast
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

## **PATIENT DISCLOSURE:**

I understand that the Report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will **not** tell me whether I have any illness, disease, or other condition 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 statements above and consent to the	
examination.	

Signature	Date