Integrated Medical Healthcare Services

Health Screening (with Breast) Questionnaire

Today's Date: _____

First Name	Last Name	Suffix	Preferred First Name

Date of Birth	Home Phone #	Cell Phone #

Street Address	Apt #	City	State	Zip Code

Email Address

Referring Physician or Provider

General Exam Disclosures

- Thermography is a no-contact, non-invasive procedure. You will be imaged with a state-of-the-art infrared camera in a comfortable, private, temperature-controlled room by a highly-trained technician.
- The value of thermography as a screening tool is its ability to measure skin temperature changes. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. Your thermal imaging report will provide information about your current condition only and **does not diagnose disease.**
- 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, disease or 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 statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement or the media.

Signature of Client* **Date**

**Typing your complete name in the appropriate field above constitutes an electronic signature.*

Breast Exam Disclosures

- Breast thermography is a no-contact, non-invasive procedure. Thermography offers information that no other procedure can provide regarding breast health. **Breast thermography does not diagnose breast disease.**
- **Breast thermography is not a replacement for or alternative to mammography or any other form of breast imaging.** Breast thermography and mammography are complementary procedures; one test does not replace the other. Studies show that clients benefit when breast thermography is used in addition to other tests or procedures. This multimodal approach includes breast self-examinations, breast exams by a doctor, mammography, ultrasound, MRI and other tests that may be ordered by your doctor.
- Interpretation of the temperature variations captured and recorded by the infrared camera used during **breast thermography does not in any way suggest diagnosis and/or treatment.**
- While a finding reported as "Thermographically Significant" does not specifically indicate the presence of disease, any such finding will be accompanied with a strong and intentional recommendation for further clinical evaluation. **If you detect a lump or any other change in your breast before your next thermogram, consult your doctor immediately.**
- ***Notice to patients presenting with previously diagnosed cancer****:* Thermography interpretation does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns. As there is no single known test capable of monitoring all biological influences of the complex disease generally diagnosed as cancer, **continued monitoring with available testing as recommended by your personal physician is strongly advised.**
- Your thermographer is a highly-skilled technician, not a licensed medical professional. Your thermographer cannot interpret your images, advise or prescribe care to you based on your images. Your thermographer can ask health history questions as well as educate you on general breast health.

By signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement or the media.

Signature of Client* **Date**

Client Acknowledgement

To the best of my knowledge, the information provided below is accurate and complete.

Signature of Client* **Date**

**Typing your complete name in the appropriate field above constitutes an electronic signature.*

Your responses below will be disclosed only to the extent necessary and/or in accordance with your written authorization.

Head & Neck

	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?	☐	☐
If yes: ☐ 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?	☐	☐
If yes, please specify: _____		
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 a history of dental problems?	☐	☐
If yes: ☐ Root canal(s) ☐ Gum disease ☐ Implants		
☐ Non-replaced extractions ☐ Dentures		
12. Have you had a dental cleaning in the past 7 days?	☐	☐
13. Have you been diagnosed with elevated cholesterol?	☐	☐

Do you have any specials concerns and/or would you like to provide 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?	☐	☐

	Left	Right
Pain/Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin changes, thickening or dimpling	☐	☐
Excretions of the nipple	☐	☐

2. Are any of the above symptoms cycle-related? ☐ ☐

3. Are you still having periods? ☐ ☐

If yes, date of last period: _____

4. Have you had a surgical hysterectomy? ☐ ☐

If yes, date: _____ ☐ Complete ☐ Partial

Reason for hysterectomy:
☐ Excess bleeding ☐ Endometriosis ☐ Fibroids
☐ Cancer ☐ Other: _____

5. Has anyone in your family ever been treated for breast cancer? ☐ ☐

If yes: ☐ Mother ☐ Grandmother ☐ Sister ☐ Daughter

6. Have you ever been diagnosed with breast cancer? ☐ ☐

If yes, date: _____

Cancer type: ☐ Local ☐ Metastatic ☐ Lymph node involvement

Left breast: ☐ Inner ☐ Outer ☐ Nipple

Right breast: ☐ Inner ☐ Outer ☐ Nipple

Treatment: ☐ Surgery ☐ Chemo ☐ Radiation ☐ None

7. Have you ever been diagnosed with any other breast disease? ☐ ☐

If yes: ☐ Cysts/fibrocystic ☐ Fibroadenoma

☐ Mastitis/inflammatory breast disease

8. Have you had any cosmetic breast surgery or implants? ☐ ☐

If yes, date: _____ ☐ Silicone ☐ Saline

Experience: ☐ Problems ☐ No problems

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 has 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 your last mammogram? _____

Were you recalled? ☐ ☐

18. Your age at your first mammogram? _____

19. Number of full-term pregnancies? _____

20. Have you had breast ultrasound? ☐ ☐

If yes, date: _____

☐ Left Results: ☐ Positive ☐ Negative

☐ Right Results: ☐ Positive ☐ Negative

21. Have you had breast MRI? ☐ ☐

If yes, date: _____

☐ Left Results: ☐ Positive ☐ Negative

☐ Right Results: ☐ Positive ☐ Negative

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?	☐	☐

Do you have any specials concerns and/or would you like to provide any details related to the information above?

_____

_____

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer with acid reflux or other digestive problems?	☐	☐	Have you had surgery or disease of the:		
			Stomach?	☐	☐
2. Do you suffer pain in the:			Spleen (Upper Left)?	☐	☐
Stomach?	☐	☐	Liver (Upper Right)?	☐	☐
Below R Breast?	☐	☐	Kidneys?	☐	☐
Below L Breast?	☐	☐	Intestines?	☐	☐
Abdomen?	☐	☐	Abdomen?	☐	☐
Lower Back?	☐	☐	Lower Back?	☐	☐
Pelvic Region?	☐	☐	Pelvic Region?	☐	☐
Have you consumed alcohol in the past 24 hours?				☐	☐