



## Comprehensive 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.**

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Signature of Client\*

Date

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

## Head & Neck

	Yes	No
1. Do you suffer with headaches? If yes: <input type="checkbox"/> Once a month or less <input type="checkbox"/> More than once a month	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have known allergies? If yes: <input type="checkbox"/> Food <input type="checkbox"/> Environmental	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have TMJ or does your jaw click?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently have a cold?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you being treated for a thyroid disorder? If yes, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have neck pain?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have upper back pain?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a known history of carotid artery disease?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have a family history of stroke?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you currently suffer with sinus problems?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a history of dental problems? If yes: <input type="checkbox"/> Root canal(s) <input type="checkbox"/> Gum disease <input type="checkbox"/> Implants <input type="checkbox"/> Non-replaced extractions <input type="checkbox"/> Dentures	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you had a dental cleaning in the past 7 days?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you been diagnosed with elevated cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any special 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?

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			Yes	No
1. Have you recently had any of these breast symptoms?			<input type="checkbox"/>	<input type="checkbox"/>
	<b>Left</b>	<b>Right</b>		
Pain/Tenderness	<input type="checkbox"/>	<input type="checkbox"/>		
Lumps	<input type="checkbox"/>	<input type="checkbox"/>		
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>		
Areas of skin changes, thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>		
Excretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>		
2. Are any of the above symptoms cycle-related?			<input type="checkbox"/>	<input type="checkbox"/>
3. Are you still having periods?			<input type="checkbox"/>	<input type="checkbox"/>
If yes, date of last period: _____				
4. Have you had a surgical hysterectomy?			<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____ <input type="checkbox"/> Complete <input type="checkbox"/> Partial				
Reason for hysterectomy:				
<input type="checkbox"/> Excess bleeding <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids				
<input type="checkbox"/> Cancer <input type="checkbox"/> Other: _____				
5. Has anyone in your family ever been treated for breast cancer?			<input type="checkbox"/>	<input type="checkbox"/>
If yes: <input type="checkbox"/> Mother <input type="checkbox"/> Grandmother <input type="checkbox"/> Sister <input type="checkbox"/> Daughter				
6. Have you ever been diagnosed with breast cancer?			<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____				
Cancer type: <input type="checkbox"/> Local <input type="checkbox"/> Metastatic <input type="checkbox"/> Lymph node involvement				
Left breast: <input type="checkbox"/> Inner <input type="checkbox"/> Outer <input type="checkbox"/> Nipple				
Right breast: <input type="checkbox"/> Inner <input type="checkbox"/> Outer <input type="checkbox"/> Nipple				
Treatment: <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> None				
7. Have you ever been diagnosed with any other breast disease?			<input type="checkbox"/>	<input type="checkbox"/>
If yes: <input type="checkbox"/> Cysts/fibrocystic <input type="checkbox"/> Fibroadenoma				
<input type="checkbox"/> Mastitis/inflammatory breast disease				

8. Have you had any cosmetic breast surgery or implants? If yes, date: _____ <input type="checkbox"/> Silicone <input type="checkbox"/> Saline Experience: <input type="checkbox"/> Problems <input type="checkbox"/> No problems	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had any biopsies or any other surgeries to your breasts? If yes, date: _____ Left breast: <input type="checkbox"/> Inner <input type="checkbox"/> Outer <input type="checkbox"/> Nipple Right breast: <input type="checkbox"/> Inner <input type="checkbox"/> Outer <input type="checkbox"/> Nipple Results: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Calcifications	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever taken contraceptive pills for more than one year? If yes: <input type="checkbox"/> Currently <input type="checkbox"/> Less than 5 years <input type="checkbox"/> More than 5 years	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you has pharmaceutical hormone replacement therapy (HRT)? If yes: <input type="checkbox"/> Currently <input type="checkbox"/> Less than 5 years <input type="checkbox"/> More than 5 years	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have an annual physical examination by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you perform a monthly breast self-exam?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been diagnosed with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
16. Total mammograms: _____		
17. Date of your last mammogram? _____ Were you recalled?	<input type="checkbox"/>	<input type="checkbox"/>
18. Your age at your first mammogram? _____		
19. Number of full-term pregnancies? _____		
20. Have you had breast ultrasound? If yes, date: _____ <input type="checkbox"/> Left Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Right Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you had breast MRI? If yes, date: _____ <input type="checkbox"/> Left Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Right Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>	<input type="checkbox"/>

## Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease?	<input type="checkbox"/>	<input type="checkbox"/>
Upper spine disorders?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you suffer with upper back pain?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you suffer with chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had surgery to your:		
Heart?	<input type="checkbox"/>	<input type="checkbox"/>
Lungs?	<input type="checkbox"/>	<input type="checkbox"/>
Mid to upper back?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have asthma or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you currently smoke?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you smoked in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any special concerns and/or would you like to provide any details related to the information above?		
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## Abdomen & Lower Back

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

## Legs & Feet

<i>Check box only if "Yes"</i>	Left	Right		Left	Right
1. Do you suffer with pain in the:			2. Have you had surgery to:		
Leg?	<input type="checkbox"/>	<input type="checkbox"/>	Leg?	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica?	<input type="checkbox"/>	<input type="checkbox"/>
Buttocks/Hip?	<input type="checkbox"/>	<input type="checkbox"/>	Buttocks/Hip?	<input type="checkbox"/>	<input type="checkbox"/>
Knees?	<input type="checkbox"/>	<input type="checkbox"/>	Knees?	<input type="checkbox"/>	<input type="checkbox"/>
Ankles?	<input type="checkbox"/>	<input type="checkbox"/>	Ankles?	<input type="checkbox"/>	<input type="checkbox"/>
Feet?	<input type="checkbox"/>	<input type="checkbox"/>	Feet?	<input type="checkbox"/>	<input type="checkbox"/>

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

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## Arms & Hands

<i>Check box only if "Yes"</i>	Left	Right		Left	Right
1. Do you suffer with pain in the:			2. Have you had surgery to:		
Shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder?	<input type="checkbox"/>	<input type="checkbox"/>
Elbow?	<input type="checkbox"/>	<input type="checkbox"/>	Elbow?	<input type="checkbox"/>	<input type="checkbox"/>
Arm?	<input type="checkbox"/>	<input type="checkbox"/>	Arm?	<input type="checkbox"/>	<input type="checkbox"/>
Hands?	<input type="checkbox"/>	<input type="checkbox"/>	Hands?	<input type="checkbox"/>	<input type="checkbox"/>
				<b>Yes</b>	<b>No</b>
3. Have you ever been diagnosed with diabetes?				<input type="checkbox"/>	<input type="checkbox"/>

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

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## Client Acknowledgement

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

Signature of Client\*

Date

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