



Breast Thermography Confidential Questionnaire

Name: _____ DOB: ____ / ____ / ____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____ Doctor: _____

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.

1. Do you have any close relative who has had breast cancer? Yes No
2. Have you ever been diagnosed with breast cancer? Yes No
3. Have you ever been diagnosed with any other breast disease (fibrocystic)? Yes No
4. Have you had any biopsies or surgeries to your breasts? Yes No
5. Have you had any breast cosmetic surgery or implants? Yes No
6. Have you had a mammogram in the past 12 months? Yes No
7. Have you had a mammogram in the past 5 years? Yes No
8. Have you had abnormal results from any breast testing? Yes No
9. Have you ever taken a contraceptive pill for more than 1 year? Yes No
10. Have you suffered with cancer of the womb? Yes No
11. Have you had pharmaceutical hormone replacement therapy? Yes No
12. Do you have an annual physical examination by a doctor? Yes No
13. Do you perform a monthly breast self-exam? Yes No
14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ Your age at birth of first child: _____
17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____
18. Do you smoke? Yes: ____ Never: ____ Not in last 12 months: ____ Not in last 5 years: ____

Have you recently had any of these breast symptoms:	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 health care 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

Today's date