BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

NAME: _____DATE OF BITH:_____

1. Do you have a close relative who has had breast cancer? ◯ Yes ◯ No Relationship: _____
2. Have you ever been diagnosed with breast cancer? ◯ Yes ◯ No - **If NO skip to question 11**

3. If YES, when: _____

4. Cancer type: ◯ Metastatic ◯ Local ◯ Lymph node involvement

5. Where (Left breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple

Where (Right breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple

6. Treatment: ◯ None ◯ Surgery ◯ Chemotherapy ◯ Radiation

7. If breast radiation treatment – date of last treatment? _____ ◯ Right breast ◯ Left breast

8. Any other treatment?_____

9. Any breast reconstruction after mastectomy? ◯ Yes ◯ No

10. If yes, what type? (ex: trans flap, implant) _____ ◯ Right breast ◯ Left breast

11. Have you ever been diagnosed with any other breast disease? ◯ Yes ◯ No

If YES, what type: ◯ Fibrocystic ◯ Cystic ◯ Mastitis ◯ Dense breast tissue ◯ Abscess Other_____

12. Have you had any biopsies or lumpectomies to your breasts? ◯ Yes ◯ No

Date: _____ Result: ◯ Positive ◯ Negative

Where (Left breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple

Where (Right breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple

13. Have you had **cosmetic** breast surgery (implants/ reduction/ lift)? ◯ Yes ◯ No Date:_____
14. Are you currently nursing? ◯ Yes ◯ No
15. Are you currently pregnant? ◯ Yes ◯ No
16. Have you had a mammogram in the past 12 months? ◯ Yes ◯ No Date: _____

Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Inconclusive - ◯ Right breast ◯ Left breast

17. Have you had a mammogram in the past 5 years? ◯ Yes ◯ No Approx Date: _____

Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Inconclusive - ◯ Right breast ◯ Left breast

18. Have you had an ultrasound in the past 12 months? ◯ Yes ◯ No Date: _____

Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Watchful - ◯ Right breast ◯ Left breast

19. Have you had an ultrasound in the past 5 years? ◯ Yes ◯ No Approx Date: _____

Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Watchful - ◯ Right breast ◯ Left breast

20. Was follow-up biopsy recommended after your most recent mammogram, ultrasound, or MRI? ◯ Yes ◯ No
21. Have you had any abnormal results from any breast testing? ◯ Yes ◯ No

If YES, briefly explain:_____

22. Have you ever taken a contraceptive pill/patch for more than 4 years? ◯ Yes ◯ No

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

NAME: _____DATE OF BITH:_____

23. Have you had pharmaceutical hormone replacement therapy?..... ◯ Yes ◯ No
24. Have you used bio-identical hormone? ◯ Yes ◯ No If yes……. ◯ gel/cream ◯ oral ◯ pellet
25. Have you been diagnosed w/ ovarian, cervical or uterine cancer? ◯ Y ◯ N If yes when?_____
26. Have you had a: ◯ Hysterectomy ◯ Oophorectomy (ovaries) ◯ Total/ radical hysterectomy (Uterus+Ovaries+Tubes)
27. Do you have an annual physical examination by a doctor?..... ◯ Yes ◯ No
28. Do you perform a monthly breast self-exam? ..... ◯ Yes ◯ No
29. How many mammograms have you had in total?_____Have you had more than 30? ◯ Yes ◯ No
30. What was your age when you had your first mammogram?_____
31. How many times have you been pregnant?_____
32. What was your age when your first child was born?_____
33. Did you start your period before the age of 12? ◯ Yes ◯ No
34. Are you still having a monthly period? ◯ Yes ◯ No
35. Did your periods finish after the age of 50? ◯ Yes ◯ No
36. Do you smoke? ◯ Yes ◯ Never ◯ Not in last 12 months ◯ Not in last 5 years
37. Have you **RECENTLY/ CURRENTLY** experienced any of these breast symptoms?

    (If yes, please mark which breast)

    Pain? ..... ◯ Left breast ◯ Right breast

    Tenderness? ..... ◯ Left breast ◯ Right breast

    Lumps? ..... ◯ Left breast ◯ Right breast

    Change in breast size? ..... ◯ Left breast ◯ Right breast

    Areas of skin thickening or dimpling? ◯ Left breast ◯ Right breast

    Secretions of the nipples?..... ◯ Left breast ◯ Right breast

    If experiencing nipple discharge – is it ◯ Bloody ◯ Milky ◯ Clear

    If nipple retraction: ◯ For many years? ◯ Recently? ◯ Left breast ◯ Right breast

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 & 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 an 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 of Patient or Patient's Authorized Representative **Today's Date**