Women's Health / Full Body / Breast Imaging

Name: _____ **Date of Birth:** _____ **Age:** _____

PRIOR IMAGING: Upper Body_____ Breast/Other_____ Full Body_____

FAMILY HISTORY: *(Mother, Father, G'parent, Sibling, Child)* ___High BP ___Stroke ___Heart Disease ___Diabetes

___Auto-Immune / Cancer / Other - _____

MY HISTORY:

Occupation:

_____

Surgeries (with dates):

Dental: ___Crown
___Root Canal
___Extractions

Current Diagnoses:

___ High BP
___ Heart Disease
___ Asthma/Lung
___ Diabetes
___ Anxiety/Depression
___ Thyroid
___ Auto-Immune
___ Other

Today's concern/s (top 3): _____

Recent Testing: _____

Show Areas of Current Pain:

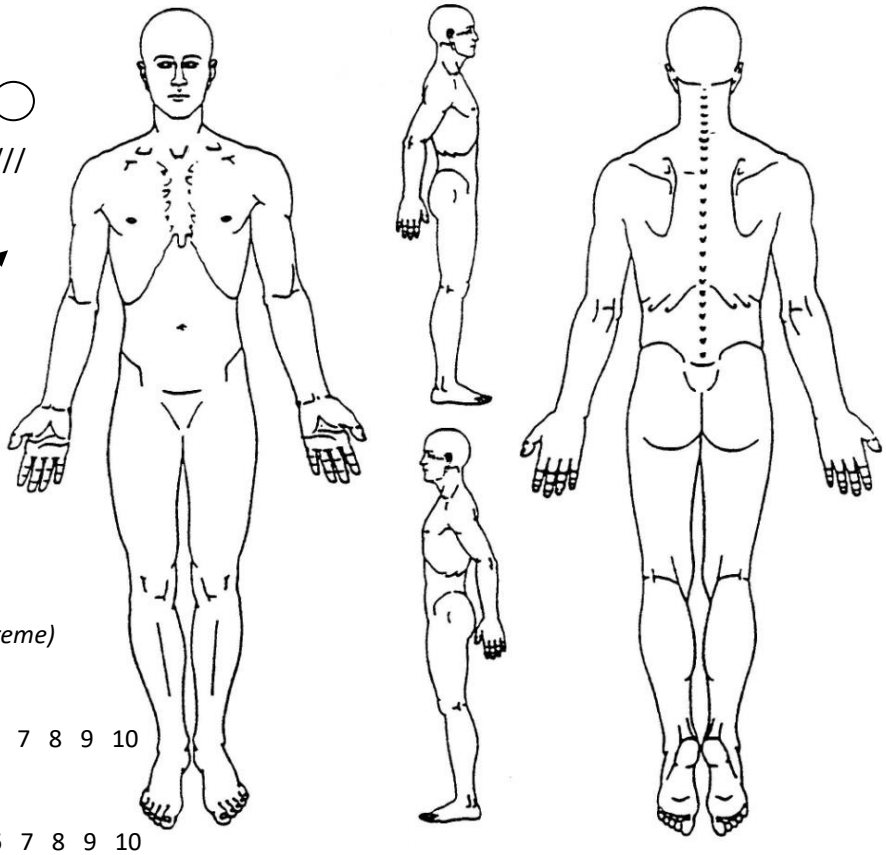
Main Pain = ✻

Secondary Pain = ◯

Numbness = ///////

Tingling = :::::

Lesions/scars = ↗



My Pain feels...

Dull / Throbbing

Sharp / Shooting

Pain Intensity is...

(0 = none, 10 = extreme)

at best:

0 1 2 3 4 5 6 7 8 9 10

at worst:

0 1 2 3 4 5 6 7 8 9 10

Pain is... (Constant / Intermittent) and I've had it for _____ (days / weeks / months)