



Women's Breast Screening

Date: ___/___/201__

Patient Name: _____

Head & Neck

Yes No

1. Do you **suffer** with headaches?
If yes: less than or equal to once per month
 more than once per month

2. Do you have 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: Type _____

6. Do you have neck pain?

7. Do you have upper back pain?

8. Do you have a history of carotid artery disease?

9. Do you have a family history of stroke?

10. Do you currently **suffer** with sinus problems?

Do you have other concerns or information related to **Head & Neck**? If so, please list below:

Breast

Is there a specific reason or concern for this exam? If YES, please explain: _____

1. Have you recently had any of these breast symptoms?

Cycle Related:

	Yes	No	If Yes: LT or RT	Yes	No
Pain/Tenderness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lumps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Change in breast size	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Areas of skin thickening or dimpling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excretions of the nipple	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Are you still having your periods?

If yes, date of last period: _____

Age when you started your period: _____

3. Have you had a surgical hysterectomy? **If yes,** date: _____ Complete Partial

Reason for hysterectomy? Excess bleeding Endometriosis Fibroid cysts Cancer Other

Patient Name: _____

5. Has anyone in your family ever been treated for breast cancer? **Yes No**
If yes, provide more detail
 Mother Age diagnosed _____ Result of Treatment _____
 Grandmother Age diagnosed _____ Result of Treatment _____
 Sister Age diagnosed _____ Result of Treatment _____
 Daughter Age diagnosed _____ Result of Treatment _____
 Other: _____ Age diagnosed _____ Result of Treatment _____

6. Have you ever been diagnosed with breast cancer? **Yes No**
If Yes:
Month _____ Year _____
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 Fibro Adenoma 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 **Yes No**

10. Have you ever taken contraceptive pills for more than one year?
If yes, Less than 5 years More than 5 years Currently Not Currently

11. Have you had pharmaceutical hormone replacement therapy (HRT)?
If yes, Less than 5 years More than 5 years Currently Not Currently

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 last mammogram _____ Were you re-called?

18. Age at your first mammogram: _____

19. Number of full term pregnancies: _____ **Yes No**

20. Have you ever had a breast ultrasound?

21. Have you ever had a breast MRI?

Do you have other concerns or information related to **Breasts**? If so, please list below: _____

Patient Name: _____

Do you have other relevant concerns or information you wish to share? If so, please list below:

Thermography Procedure:

- You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings.
- Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose disease.
- Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other examination.

Patient Disclosure:

- 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, diseases, or other conditions, 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.

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist at Physician's Insight, and any other practitioner that you specify.

Acceptance:

Signature: _____ Date: _____