Thermography Health History

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Women's Full Body Screening

Date:___/___/201__

Patient Name: ____

Head & Neck

	Yes	No
1. Do you ***suffer*** with headaches?	o	o
If yes: o less than or equal to once per month		
o more than once per month		
2. Do you have allergies?	o	o
If yes: Food _____ Environmental_____		
3. Do you have TMJ or does your jaw click?	o	o
4. Do you currently have a cold?	o	o
5. Are you being treated for a thyroid disorder?	o	o
If yes: Type____		
6. Do you have neck pain?	o	o
7. Do you have upper back pain?	o	o
8. Do you have a history of carotid artery disease?	o	o
9. Do you have a family history of stroke?	o	o
10. Do you currently ***suffer*** with sinus problems?	o	o

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?

	Yes	No	If Yes: LT	or RT	Cycle Related: Yes	No
Pain/Tenderness	o	o	o	o	o	o
Lumps	o	o	o	o	o	o
Change in breast size	o	o	o	o	o	o
Areas of skin thickening or dimpling	o	o	o	o	o	o
Excretions of the nipple	o	o	o	o	o	o

2. Are you still having your periods? o o

If yes, date of last period: ____________

Age when you started your period: ______

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

Reason for hysterectomy? o Excess bleeding o Endometriosis o Fibroid cysts o Cancer o Other

Patient Name: ____

4. 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_________________________

5. 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: ____

Chest, Heart & Lungs

Question	Yes	No
1. Have you been diagnosed with:		
Heart disease?	o	o
Lung disease?	o	o
Upper spine disorders?	o	o
2. Do you ***suffer*** with upper back pain?	o	o
3. Do you ***suffer*** with chest pain?	o	o
4. Have you ever had surgery to your:		
Heart?	o	o
Mid to upper back?	o	o
Lungs?	o	o
5. Do you have asthma or shortness of breath?	o	o
6. Do you currently smoke?	o	o
7. Have you smoked in the past 5 years?	o	o

Do you have other concerns or information related to ***Chest, Heart & Lungs***? If so, please list below:

____

Abdomen & Lower Back

Question	Yes	No
1. Do you ***suffer*** with acid reflux?	o	o

2. Do you ***suffer*** pain in the:

	Yes	No		Yes	No
Stomach?	o	o	Abdomen?	o	o
Below R Breast?	o	o	Lower Back?	o	o
Below L Breast?	o	o	Pelvic Region?	o	o

Have you had surgery or disease in the:

	Yes	No		Yes	No
Stomach?	o	o	Intestines?	o	o
Spleen(Upper Left)?	o	o	Abdomen?	o	o
Liver(Upper Right)?	o	o	Lower Back?	o	o
Kidneys?	o	o	Pelvic Region?	o	o

Question	Yes	No
Have you consumed ANY alcohol in the past 24 hours?	o	o

Do you have other concerns or information related to ***Abdomen & Lower Back***? If so, please list below:

____

Legs & Feet

1. Do you ***suffer*** pain in the:

	Yes	No	Rt or Lt	
Leg	o	o	o	o
Sciatica	o	o	o	o
Buttocks/Hip	o	o	o	o
Knees	o	o	o	o
Feet	o	o	o	o
Ankles	o	o	o	o

Patient Name: ____

2. Have you had surgery to the:

	Yes	No	Rt	Lt
Leg	o	o	o	o
Sciatica	o	o	o	o
Buttocks/Hip	o	o	o	o
Knees	o	o	o	o
Feet	o	o	o	o
Ankles	o	o	o	o

Do you have other concerns or information related to ***Legs and Feet***? If so, please list below:

____

Arms & Hands

		Yes	No	Rt or Lt	
1. Do you suffer with pain in the:	Shoulder	o	o	o	o
	Elbow	o	o	o	o
	Arm	o	o	o	o
	Hands	o	o	o	o
2. Have you had surgery to:	Shoulder	o	o	o	o
	Elbow	o	o	o	o
	Arm	o	o	o	o
	Hands	o	o	o	o
3. Have you ever been diagnosed with diabetes?		o	o		

Do you have other concerns or information related to ***Arms and Hands***? If so, please list below:

____

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: ______________________