Thermography Health History

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Women's Upper Body 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?

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

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: ____

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

	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

	Yes	No		Yes	No
1. Do you ***suffer*** with acid reflux?	o	o			
2. Do you ***suffer*** pain in the:					
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:					
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
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:

____

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

____

Patient Name: ____

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: ___________________________________