

Name: _____ Birthdate: _____ Doctor: _____
 Address: _____ City _____ Zip _____
 Email: _____ Phone: _____

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

Breast Thermography Confidential Questionnaire

	Yes	No
Do you have any close relative who has had breast cancer? _____	___	___
Have you ever been diagnosed with breast cancer? _____	___	___
Have you ever been diagnosed with any other breast disease (fibrocystic)? _____	___	___
Have you had any biopsies or surgeries to your breasts? _____	___	___
Have you had any breast cosmetic surgery or implants? _____	___	___
Have you had a mammogram in the past 12 months? _____	___	___
Have you had a mammogram in the past 5 years? _____	___	___
Have you had abnormal results from any breast testing? _____	___	___
Have you ever taken a contraceptive pill for more than 1 year? _____	___	___
Have you suffered with cancer of the womb? _____	___	___
Have you had pharmaceutical hormone replacement therapy? _____	___	___
Do you have an annual physical examination by a doctor? _____	___	___
Do you perform a monthly breast self exam? _____	___	___
Did your periods start before the age of 12? _____	___	___
Or finish after the age of 50? _____	___	___
How many mammograms have you had in total? _____		
What was your age when you had your first mammogram? _____		
How many births have you had? _____		
Your age at birth of first child: _____		
Do you smoke? Yes: Never: Not in last 12 months: Not in last 5 years:		

Have you recently had any of these breast symptoms:	Right Breast.	Left Breast
Pain	___	___
Tenderness	___	___
Lumps	___	___
Change in breast size	___	___
Areas of skin thickening or dimpling	___	___
Secretions of the nipple	___	___

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 and 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 any 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 Today's date _____