

Confidential Questionnaire
Women's Full Body

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State ____ Zip _____

Phone Number (home) _____ (cellular) _____ (work) _____

Email Address _____ Referring Physician _____

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

Head & Neck

Yes No

- | | | |
|--|-----|-----|
| 1. Do you suffer with headaches?
If yes, once a month or less _____ more than one a month _____ | ___ | ___ |
| 2. Do you have known allergies? 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? 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? | ___ | ___ |
| 11. Do you have history of dental problems?
Root Canals _____ Gum Disease _____ Implants _____
Non-Replaced Extractions _____ Dentures _____ | ___ | ___ |
| 12. Have you had a dental cleaning in the past 7 days? | ___ | ___ |
| 13. Have you been diagnosed with elevated cholesterol? | ___ | ___ |

Do you have any special concerns or are there any details related to the information above?

Breast

Is there a specific reason or concern for this breast exam?

- | | Yes | No |
|--|-----|-----|
| 1. Have you recently had any of these breast symptoms? (Mark only if "Yes") | ___ | ___ |
| Pain/Tenderness | | |
| RT___ LT___ | | |
| Lumps | | |
| RT___ LT___ | | |
| Change in breast size | | |
| RT___ LT___ | | |
| Areas of skin changing, thickening or dimpling | | |
| RT___ LT___ | | |
| 2. Are any of the above symptoms cycle related? | ___ | ___ |
| 3. Are you still having periods? If yes, date of last period _____ | ___ | ___ |
| 4. Have you had a surgical hysterectomy? | ___ | ___ |
| If yes, date _____ Complete ___ Partial ___ | | |
| Reason for hysterectomy (Circle) | | |
| Excess Bleeding Endometriosis Fibroid Cysts Cancer Other _____ | | |
| 5. Has anyone in your family ever been treated for breast cancer? | ___ | ___ |
| If yes, circle: Mother Grandmother Sister Daughter | | |
| Age Diagnosed _____ Result of Treatment _____ | | |
| 6. Have you ever been diagnosed with breast cancer? | ___ | ___ |
| If yes, date: Month _____ Year _____ | | |
| Cancer Type (Circle): Local Metastatic Lymph Node Involvement | | |
| Left Breast: Inner Outer Nipple | | |
| Right Breast: Inner Outer Nipple | | |
| Treatment: Surgery Chemo Radiation None Other _____ | | |
| If Surgery: Mastectomy Lumpectomy | | |
| 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 _____ Type (circle): Silicone Saline | | |
| Experience (circle): No problems 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

10. Have you ever taken contraceptive pills for more than one year?

If yes, circle: Currently Less than 5 years More than 5 years

11. Have you had pharmaceutical hormone replacement therapy (HRT)?

If yes, circle: Currently Less than 5 years More than 5 years

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. Have you had a mammogram? Number of mammograms _____

17. Date of last mammogram _____ Were you re-called?

18. Your age at your first mammogram: _____

19. Number of full-term pregnancies? _____

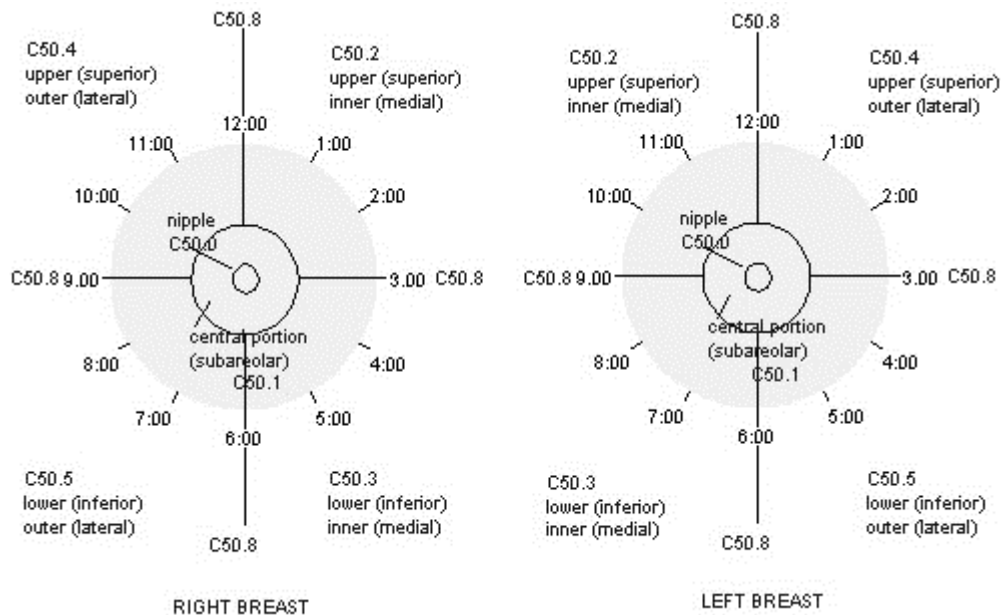
20. Have you had a breast ultrasound?

If yes, date _____ Left _____ Right _____ Results: Negative _____ Positive _____

21. Have you had a breast MRI?

If yes, date _____ Left _____ Right _____ Results: Negative _____ Positive _____

Mark on the following graph to indicate location of pain, surgery, or lumps:



Chest, Heart, & Lungs

Yes No

- | | | |
|---|-----|-----|
| 1. Have you been diagnosed with... | | |
| a. Heart Disease? | ___ | ___ |
| b. Lung Disease? | ___ | ___ |
| c. Upper Spine Disorders? | ___ | ___ |
| 2. Do you suffer with upper back pain? | ___ | ___ |
| 3. Do you suffer with chest pain? | ___ | ___ |
| 4. Have you ever been diagnosed with scoliosis? | ___ | ___ |
| 5. Have you ever had surgery to your... | | |
| a. Heart? | ___ | ___ |
| b. Lungs? | ___ | ___ |
| c. Mid to Upper Back? | ___ | ___ |
| 6. Do you have asthma or shortness of breath? | ___ | ___ |
| 7. Do you currently smoke? | ___ | ___ |
| 8. Have you smoked in the past 5 years? | ___ | ___ |
| 9. Do you suffer from shoulder pain? | ___ | ___ |

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

- | | |
|---|--|
| 1. Do you suffer with acid reflux or other digestive problems? Y___ N___ | 3. Have you had surgery or disease in the... |
| 2. Do you suffer pain in the... | Stomach? Y___ N___ |
| Stomach? Y___ N___ | Spleen (Upper Left)? Y___ N___ |
| Below R Breast? Y___ N___ | Liver (Upper Right)? Y___ N___ |
| Below L Breast? Y___ N___ | Kidneys? Y___ N___ |
| Abdomen? Y___ N___ | Intestines? Y___ N___ |
| Lower Back? Y___ N___ | Abdomen? Y___ N___ |
| Pelvic Region? Y___ N___ | Lower Back? Y___ N___ |
| | Pelvic Region? Y___ N___ |
| 4. Have you consumed alcohol in the past 24 hours? Y___ N___ | |

Lower Extremities Related Pain

Check only if "Yes"

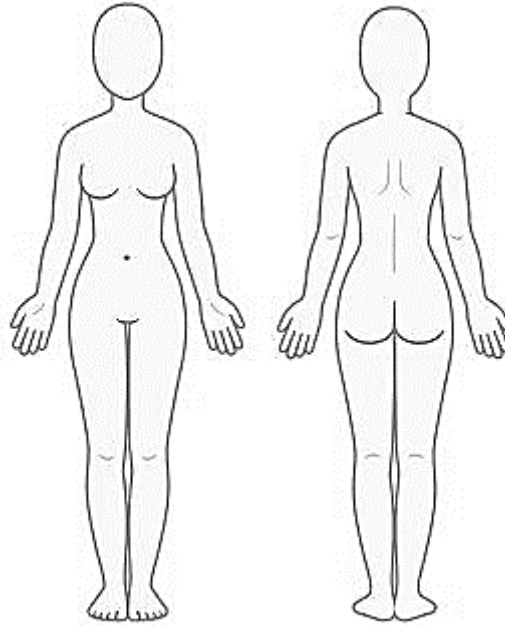
- | | |
|----------------------------------|-------------------------------------|
| 1. Do you suffer pain in the... | 2. Have you had surgery to... |
| Leg? LT__ RT__ | 3. Leg? LT__ RT__ |
| Sciatica? LT__ RT__ | 4. Sciatica? LT__ RT__ |
| Buttocks/Hip? LT__ RT__ | 5. Buttocks/Hip? LT__ RT__ |
| Knees? LT__ RT__ | 6. Knees? LT__ RT__ |
| Ankles? LT__ RT__ | 7. Ankles? LT__ RT__ |
| Feet? LT__ RT__ | 8. Feet? LT__ RT__ |

Arms & Hands

- | | |
|---------------------------------|---------------------------------|
| 1. Do you suffer pain in the... | 2. Have you had surgery to ... |
| Shoulder? LT__ RT__ | Shoulder? LT__ RT__ |
| Elbow? LT__ RT__ | Elbow? LT__ RT__ |
| Arm? LT__ RT__ | Arm? LT__ RT__ |
| Hands? LT__ RT__ | Hands? LT__ RT__ |

Do you have any special concerns or are there any details related to the information above?

Mark Areas of Pain to indicate location of pain, surgery, or injury:



Areas of Pain

Do you have any special concerns or are there any details related to the information above? Please provide dates and specific details related to surgeries or treatments.

Client Contract and Treatment Consent Form

Thermography is a non-contact, private, and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes suggesting inflammatory response to injury or metabolic effects of tissue disturbance. **It offers men and women supportive information that no other procedure can provide regarding general health. Breast thermography is not a replacement for or alternative to mammography or any other form of breast imaging.** Breast thermography, mammography, or breast ultrasounds are complementary procedures: one test does not replace the other. Breast thermography is meant to be used in addition to other tests or procedures.

This information does not in any way suggest diagnosis and/or treatment. Studies show that the patient benefits when multiple tests are used in combination. This multimodal approach includes breast self-examinations, physical breast exams by a licensed healthcare provider, mammography, ultrasound, MRI, and other tests that may be ordered by your doctor. ***A reported “elevated level of concern” finding does not indicate that is suspicious for any specific disease.*** However, any suspicious finding will be accompanied by a strong and intentional recommendation for further clinical evaluation. If you detect a lump or any other change in your breast before your next thermography study, consult your doctor immediately.

Notice to clients presenting with previously diagnosed conditions including cancer:

Thermography interpretation in your report **does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns.** As there is no single known test capable of monitoring all biological influences of the complex diseases, **continued monitoring with available additional testing as recommended by your personal physician is strongly advised.**

Your thermographer may not be a licensed medical professional. **Your thermographer cannot interpret your images or advise or prescribe to you based on your images.** Your thermographer can ask health history questions, as well as educate you on general breast health.

By signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement.

Client Signature _____ Today's Date _____