thermography Medical Clinic

Physicians INSIGHT Clinical Interpretation

Confidential Questionnaire – Women's Health Screening

Patient's Name	**Report Date**
D.O.B.	**Referring Physician**
Address	**City**
Province	**Postal Code**
Home Phone	**Cellular Phone**
Work Phone	**E-Mail**

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.

HEAD & NECK	**YES**	**NO**
Do you suffer with headaches?	◯	◯
If yes, ◯ once a month or less ◯ more than once a month		
Do you have allergies?	◯	◯
Do you have TMJ or does your jaw click?	◯	◯
Do you currently have a cold?	◯	◯
Are you being treated for a thyroid disorder?	◯	◯
Do you have neck pain?	◯	◯
Do you have upper back pain?	◯	◯
Do you have a history of carotid artery disease?	◯	◯
Do you have a family history of stroke?	◯	◯
Do you currently suffer with sinus problems?	◯	◯

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

BREAST

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

	YES	NO
Have you recently had any of these breast symptoms?	◯	◯
LT RT Pain/Tenderness ☐ ☐ Lumps ☐ ☐ Change in breast size ☐ ☐ Areas of skin thickening or dimpling ☐ ☐ Excretions of the nipple ☐ ☐		
Are any of the above symptoms related to your cycle?	◯	◯
Are you still having periods?	◯	◯
If Yes, date of last period		
Have you had a surgical Hysterectomy?	◯	◯
If Yes, Date Complete ◯ Partial ◯		
Reason for Hysterectomy?		
◯ Excess bleeding ◯ Endometrosis ◯ Fibroid Cysts ◯ Cancer ◯ Other		
Has anyone in your family ever been treated for breast cancer?	◯	◯
If Yes, ☐ Mother ☐ Grandmother ☐ Sister ☐ Daughter		
If Yes, Age diagnosed Survived:	◯	◯
Have you ever been diagnosed with breast cancer?	◯	◯
If Yes, Date		
Cancer type ☐ Local ☐ Metastatic ☐ Lymph node involvement Left breast ☐ Inner ☐ Outer ☐ Nipple Right breast ☐ Inner ☐ Outer ☐ Nipple Treatment ☐ Surgery ☐ Chemo ☐ Radiation ☐ None		
Have you ever been diagnosed with any other breast disease?	◯	◯
If Yes, ☐ Cysts/fibrocystic ☐ Mastitis/inflammatory breast disease ☐ Fibro Adenoma		

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Have you ever had any cosmetic breast surgery or implants?	◯	◯
If yes, Date Type: ◯ Silicone ◯ Saline Experience: ◯ Problems ◯ No Problems		
Have you ever had any biopsies or other surgeries to your breasts?	◯	◯
If yes, Date Left breast ☐ Inner ☐ Outer ☐ Nipple Right breast ☐ Inner ☐ Outer ☐ Nipple Results ☐ Negative ☐ Positive ☐ Calcifications		
Have you ever taken contraceptive pills for more than one year?	◯	◯
If Yes, ◯ Currently ◯ Less than 5 years ◯ More than 5 years		
Have you ever had pharmaceutical hormone replacement therapy (HRT)?	◯	◯
If Yes, ◯ Currently ◯ Less than 5 years ◯ More than 5 years		
Do you have an annual physical examination by a doctor?	◯	◯
Do you perform a monthly breast self-exam?	◯	◯
Have you ever smoked?	◯	◯
Have you ever been diagnosed with diabetes?	◯	◯
Date of your last mammogram		
Were you re-called?	◯	◯
How many mammograms have you had in total?	◯	◯
Your age at your first mammogram?	◯	◯
Number of full term pregnancies?	◯	◯
Your age at birth of your first child?	◯	◯
Age when you started your period?	◯	◯

CHEST, HEART, LUNGS

	YES	NO
Have you been diagnosed with		
Heart Disease	◯	◯
Lung Disease	◯	◯
Upper Spine Disorders	◯	◯
Do you suffer with upper back pain?	◯	◯
Do you suffer with chest pain?	◯	◯

Have you ever had surgery to your:		
Heart	◯	◯
Lungs	◯	◯
Mid to upper back	◯	◯
Do you have Asthma or shortness of breath?	◯	◯
Do you currently smoke?	◯	◯
Have you smoked in the past 5 years?	◯	◯

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

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 breast 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 breast 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.

Patient Signature _____ Today's Date _____