Thermalogica Health Screening

Breast Thermography Confidential Questionnaire

Name: _____

Date of Birth: _____ **(dd/mm/yy)**

Address: _____

Town: _____

County: _____ **Postcode:** _____

Contact No: _____

E-Mail: _____

Doctor: _____

	Please mark Yes or No as it applies to You:	**Yes**	**No**
1	Do you have any close relative who has had breast cancer?		
2	Have you ever been diagnosed with breast cancer?		
3	Have you ever been diagnosed with any other breast disease (fibrocystic)?		
4	Have you had any biopsies or surgeries to your breasts?		
5	Have you had any breast cosmetic surgeries or implants?		
6	Have you had a mammogram in the past 12 months?		
7	Have you had a mammogram in the past 5 years?		
8	Have you had abnormal results from any breast testing?		
9	Have you ever taken a contraceptive pill for more than a year?		
10	Have you suffered with cancer of the womb?		
11	Have you had pharmaceutical hormone replacement therapy?		
12	Do you have an annual physical examination by a doctor?		
13	Do you perform a monthly breast self exam?		

Breast Thermography Confidential Questionnaire

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 the birth of your first child:
Did your periods start before the age of 12? Or finish after the age of 50?
Do you smoke? Yes Not in the last 12 months Not in the last 5 years Never
Had a vaccination in last 4 weeks? Indicate which arm: Left: Right: No:

Have you recently had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	**Right Breast**	**Left Breast**
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

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.

PATIENT DISCLOSURE: PLEASE READ CAREFULLY

I understand that the Report generated from my images is intended for the 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: _____

Date: _____

Would you like a copy of this report sent to your doctor or healthcare professional? Y/N

Thermalogica
Health Screening

Extended Breast Questionnaire

Patient Name: _____ **Date:** _____

Diagnosed with breast cancer:

Cancer type: Metastatic: _____ Local: _____ Lymph node involvement: _____

When Diagnosed: Month: _____ Year: _____

Where (Left Breast): UO____ UI_____ LO_____ LI_____ Nipple____

Where (Right Breast): UO____ UI_____ LO_____ LI_____ Nipple____

Treatment: Surgery____ Chemo____ Radiation____ Other____ None____

Diagnosed with other breast disease:

Disease Type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other____
(Please report other types of disease in the history)

Breast biopsies or surgery:

Where (Left Breast): OU____ UI____ LO____ LI____ Nipple____

Where (Right Breast): OU____ UI____ LO____ LI____ Nipple____

Any further information or notes for client file – please write below: