



# Confidential Questionnaire

## Breast

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number Home \_\_\_\_\_ Cellular \_\_\_\_\_ Work \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_  
 Referring Physician \_\_\_\_\_

Is there a specific reason or concern for this exam?

**Yes**      **No**

- |   |                               |                                  |  |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
|---|-------------------------------|----------------------------------|--|--|-------------|-----------------------------|-----------------------------|------------------------------|--------------|-----------------------------|-----------------------------|------------------------------|-----------------------|-------------------------------|-----------------------------|--|-----------------------|-----------------------|--|-----------------------|--------------------------------------|-----------------------|-----------------------|--|-----------------------|--------------------------|-----------------------|-----------------------|--|-----------------------|-----------------------|-----------------------|
| <p>1. Have you recently had any of these breast symptoms?</p> <table border="0" style="width: 100%; margin-left: 40px;"> <tr> <td></td> <td style="text-align: center;"><b>RT</b></td> <td style="text-align: center;"><b>LT</b></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td>Pain/Tenderness</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Lumps</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Change in breast size</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Areas of skin thickening or dimpling</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Excretions of the nipple</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table> |                               | <b>RT</b>                        | <b>LT</b>  |  |             | Pain/Tenderness             | <input type="radio"/>       | <input type="radio"/>        |              | <input type="radio"/>       | Lumps                       | <input type="radio"/>        | <input type="radio"/> |                               | <input type="radio"/>       | Change in breast size                                      | <input type="radio"/> | <input type="radio"/> |  | <input type="radio"/> | Areas of skin thickening or dimpling | <input type="radio"/> | <input type="radio"/> |  | <input type="radio"/> | Excretions of the nipple | <input type="radio"/> | <input type="radio"/> |  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|   | <b>RT</b>                     | <b>LT</b>                        |  |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Pain/Tenderness   | <input type="radio"/>         | <input type="radio"/>            |  | <input type="radio"/>                        |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Lumps   | <input type="radio"/>         | <input type="radio"/>            |  | <input type="radio"/>                        |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Change in breast size   | <input type="radio"/>         | <input type="radio"/>            |  | <input type="radio"/>                        |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Areas of skin thickening or dimpling  | <input type="radio"/>         | <input type="radio"/>            |  | <input type="radio"/>                        |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Excretions of the nipple  | <input type="radio"/>         | <input type="radio"/>            |  | <input type="radio"/>                        |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| <p>2. Are any of the above symptoms cycle related?</p>  | <input type="radio"/>         | <input type="radio"/>            |  |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| <p>3. Are you still having your periods?<br/>       If yes, date of last period _____</p>   | <input type="radio"/>         | <input type="radio"/>            |  |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| <p>4. Have you had a surgical hysterectomy?<br/>       If yes, date _____      <input type="radio"/> Complete    <input type="radio"/> Partial<br/>       Reason for hysterectomy?<br/> <input type="radio"/> Excess bleeding   <input type="radio"/> Endometriosis   <input type="radio"/> Fibroid cysts   <input type="radio"/> Cancer   <input type="radio"/> Other</p>  | <input type="radio"/>         | <input type="radio"/>            |  |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| <p>5. Has anyone in your family ever been treated for breast cancer?<br/>       If yes,    <input type="radio"/> Mother      <input type="radio"/> Grandmother      <input type="radio"/> Sister      <input type="radio"/> Daughter</p>  | <input type="radio"/>         | <input type="radio"/>            |  |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| <p>6. Have you ever been diagnosed with breast cancer?<br/>       If yes, date _____</p> <table border="0" style="width: 100%; margin-left: 40px;"> <tr> <td>Cancer type</td> <td><input type="radio"/> Local</td> <td><input type="radio"/> Metastatic</td> <td><input type="radio"/> Lymph node involvement</td> </tr> <tr> <td>Left breast</td> <td><input type="radio"/> Inner</td> <td><input type="radio"/> Outer</td> <td><input type="radio"/> Nipple</td> </tr> <tr> <td>Right breast</td> <td><input type="radio"/> Inner</td> <td><input type="radio"/> Outer</td> <td><input type="radio"/> Nipple</td> </tr> <tr> <td>Treatment</td> <td><input type="radio"/> Surgery</td> <td><input type="radio"/> Chemo</td> <td><input type="radio"/> Radiation      <input type="radio"/> None</td> </tr> </table>   | Cancer type                   | <input type="radio"/> Local      | <input type="radio"/> Metastatic                           | <input type="radio"/> Lymph node involvement | Left breast | <input type="radio"/> Inner | <input type="radio"/> Outer | <input type="radio"/> Nipple | Right breast | <input type="radio"/> Inner | <input type="radio"/> Outer | <input type="radio"/> Nipple | Treatment             | <input type="radio"/> Surgery | <input type="radio"/> Chemo | <input type="radio"/> Radiation <input type="radio"/> None | <input type="radio"/> | <input type="radio"/> |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Cancer type   | <input type="radio"/> Local   | <input type="radio"/> Metastatic | <input type="radio"/> Lymph node involvement               |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Left breast   | <input type="radio"/> Inner   | <input type="radio"/> Outer      | <input type="radio"/> Nipple                               |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Right breast  | <input type="radio"/> Inner   | <input type="radio"/> Outer      | <input type="radio"/> Nipple                               |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |
| Treatment   | <input type="radio"/> Surgery | <input type="radio"/> Chemo      | <input type="radio"/> Radiation <input type="radio"/> None |  |             |                             |                             |                              |              |                             |                             |                              |                       |                               |                             |  |                       |                       |  |                       |                                      |                       |                       |  |                       |                          |                       |                       |  |                       |                       |                       |



# Confidential Questionnaire

## Breast

- |   | <b>Yes</b>            | <b>No</b>             |
|---|-----------------------|-----------------------|
| 7. Have you ever been diagnosed with any other breast disease?  | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="radio"/> Cysts/fibrocystic <input type="radio"/> Mastitis/inflammatory breast disease              |                       |                       |
| 8. Have you had any cosmetic breast surgery or implants?  | <input type="radio"/> | <input type="radio"/> |
| If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline  |                       |                       |
| Experience <input type="radio"/> Problems <input type="radio"/> No problems   |                       |                       |
| 9. Have you ever had any biopsies or any other surgeries to your breasts?   | <input type="radio"/> | <input type="radio"/> |
| If yes, date _____  |                       |                       |
| Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple                        |                       |                       |
| Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple                       |                       |                       |
| Results <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Calcifications              |                       |                       |
| 10. Have you ever taken contraceptive pills for more than one year?   | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years |                       |                       |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)?  | <input type="radio"/> | <input type="radio"/> |
| If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years |                       |                       |
| 12. Do you have an annual physical examination by a doctor?   | <input type="radio"/> | <input type="radio"/> |
| 13. Do you perform a monthly breast self exam?  | <input type="radio"/> | <input type="radio"/> |
| 14. Have you ever smoked?   | <input type="radio"/> | <input type="radio"/> |
| 15. Have you ever been diagnosed with diabetes?   | <input type="radio"/> | <input type="radio"/> |
| 16. Date of your last mammogram _____ Were you re-called? _____   | <input type="radio"/> | <input type="radio"/> |



# Confidential Questionnaire

## *Breast*

17. How many mammograms have you had in total? \_\_\_\_\_
18. Your age at your first mammogram? \_\_\_\_\_
19. Number of full term pregnancies? \_\_\_\_\_
20. Your age at birth of your first child? \_\_\_\_\_
21. Age when you started your period? \_\_\_\_\_

Do you have any special concerns or are there 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 \_\_\_\_\_