

Breast Thermography Confidential Questionnaire

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Any close relative who has had breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ever been diagnosed with breast cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been diagnosed with any other breast disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had any biopsies or surgeries to breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had any breast cosmetic surgery or implants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Had a mammogram in the past 12 months? Date | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Had a mammogram in the past 5 years? Date | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Any abnormal results from any breast testing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever taken a contraceptive pill for more than 1 year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever suffered with cancer of the womb? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever had pharmaceutical hormone replacement therapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have an annual physical examination by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Perform a monthly breast self exam? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Total mammograms? <input style="width: 50px;" type="text"/> | | |
| 15. Age at first mammogram? <input style="width: 50px;" type="text"/> | | |
| 16. Children given birth to? <input style="width: 50px;" type="text"/> | | |
| 17. Age at birth of first child? <input style="width: 50px;" type="text"/> | | |
| 18. Periods started before age of 12? <input style="width: 50px;" type="text"/> | | |
| 19. Or finished after the age of 50? <input style="width: 50px;" type="text"/> | | |
| 20. Smoker? Yes <input type="checkbox"/> Never <input type="checkbox"/> Not in last 12 months <input type="checkbox"/> Not in last 5 years <input type="checkbox"/> | | |

Recently had any of these breast symptoms:

Pain?

Left Breast

Tenderness?

Lumps?

Change in breast size?

Areas of skin thickening or dimpling?

Secretions of the nipple?

Right Breast

Patient Initials: _____

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 (refer history)

Breast biopsies or surgery:

Where (left breast): UO UI LO LI Nipple

Where (right breast): UO UI LO LI Nipple

Patient Initials: _____