Name: ____ Birthdate:________________________

Breast Thermography Confidential Questionnaire

#	Question	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 every been diagnosed with any other breast disease (fibrocystic)? >>>>>>>>>>>>>>>>>>>>>>>>	☐	☐
4.	Have you had any biopsies/lumpectomy to your breasts? Date____________ Result Positive/Negative>>>	☐	☐
5.	Have you had any breast cosmetic surgery or implants? Date______________ >>>>>>>>>>>>>>>>>>>>>	☐	☐
6.	Have you had a mammogram in the past 12 months? Date __________Result Positive/Negative>>>>>>>>	☐	☐
7.	Have you had a mammogram in the past 5 years? Approx. date _____________>>>>>>>>>>>>>>>>>>>>	☐	☐
8.	Have you had any abnormal results from any breast testing? If yes, briefly explain >>>>>>>>>>>>>>>>>>> ____	☐	☐
9.	Have you ever taken a contraceptive pill/patch for more than 1 year? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	☐	☐
10.	Have you been diagnosed with cervical or uterine cancer? >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	☐	☐
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?>>	☐	☐

How many mammograms have you had in total? _________________

What was your age when you had your first mammogram? _________

How many births have you had? _______ What was your age at the birth of your first child? ________

Did your period start before the age of 12? ________ Did it finish after the age of 50? ________

Do you smoke? Yes:_____ Never: _______ Not in last 12 months: ______ Not in last 5 or more years: ______

Have you recently / currently experienced these breast symptoms:	RIGHT breast	LEFT breast
Pain >>	☐	☐
Tenderness >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	☐	☐
Lumps >>>	☐	☐
Change in breast size >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	☐	☐
Areas of skin thickening or dimpling >>>>>>>>>>>>>>>>>>	☐	☐
Secretions of the nipples >>>>>>>>>>>>>>>>>>>>>>>>>>>>	☐	☐

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for 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 ____Today's date _____________________