

Breast Thermography Confidential Questionnaire

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.

Name:		Date:	
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		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 cosmetic breast surgery 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 1 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?		
14.	Did your periods start before the age of 12?		
15.	Did your periods finish after the age of 50?		

Total mammograms so far:		Age of first mammogram	
Number of children give birth to:		Age at birth of first child:	

Do you smoke?	Yes		Never		Not in last 12 months		Not in last 5 years	
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Date of Covid-19 Vaccination		Which Arm?	
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Recent breast symptoms:

	Right breast	Left breast
Pain or Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Any secretions from the nipples		

Extended Breast Questionnaire

Name:	Date:
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Diagnosed with breast cancer:

Cancer type:	Metastatic	Local	Lymph node involvement
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Date of diagnosis:	Month:	Year:
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Where was cancer diagnosed?



Treatment:

Surgery	Chemo	Radiation	Other	None
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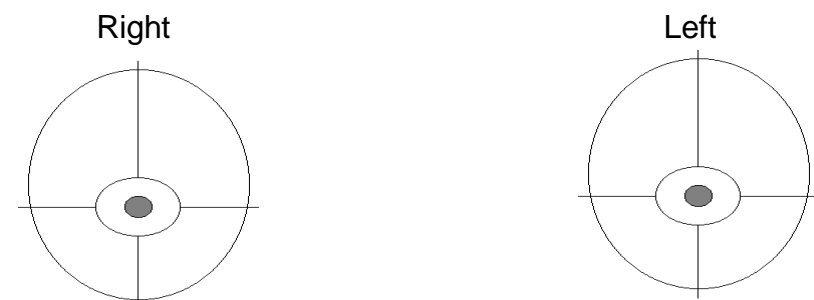
Diagnosed with other breast disease:

Disease type:	Fibrocystic	Cystic	Abscess
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Other breast diseases:

Breast biopsies or surgery:

Where did biopsies or surgery occur?



<p>PATIENT DISCLOSURE</p> <p>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 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 of the areas discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination</p>
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Signature: _____ Date: _____