Midwest Medical Thermography

PATIENT INFORMATION SHEET

(This information is confidential)

NAME: _____ DOB: _____AGE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION: _____

Current Health Problems:

Previous Illnesses:

Previous Surgery (by date):

Family History (parents/siblings):

Medication: _____

Other Treatment: _____

Physician: _____

All information is correct to my knowledge.

Signed: _____ Date: _____

For office use only

Scan Type: _____ PT ID: _____ Rpt. #: _____ Location: _____

Referred by: _____ EMI: ___ E-mailed: ___ Call: ___ Mailed: ___ ROF: ___ Keap: ___

Payment: $_____ Cash/CC/Check # _____ Rcpt: Y / N mail/email DH: $_____

Midwest Medical Thermography

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:_____D.O.B: _____

Please show areas of:

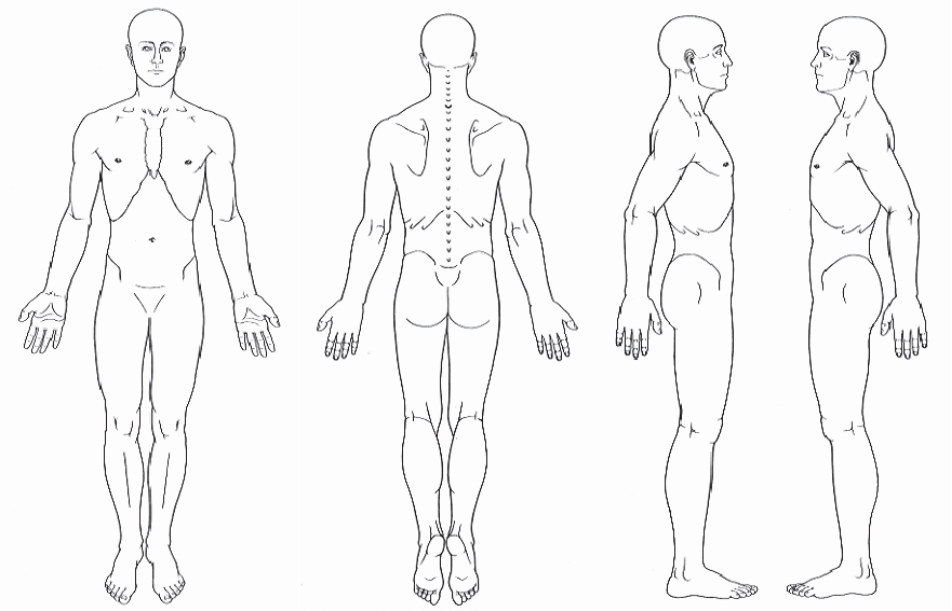
Main Pain ✳

Secondary Pain O

Numbness ////////

Pins & Needles ::::::::

Skin Lesions/Scars ↗



Do you know what triggered the pain?

Does anything relieve it?

Does anything aggravate it?

Has it changed since it began?

Have you had any treatment?

History: Injuries / Fractures / Surgery

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 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.

Signature:_____ **Date:**_____

Name: _____ **Birthdate:** _____

Address: _____ **City** _____ **Zip** _____

Email: _____ **Phone:** _____ **Doctor:** _____

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Breast Thermography Confidential Questionnaire

	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 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. How many mammograms have you had in total? _____

15. What was your age when you had your first mammogram? _____

16. How many births have you had? _____ **Your age at birth of first child:** _____

17. Did your periods start before the age of 12? _____ **Or finish after the age of 50?** _____

18. Do you smoke? Yes: ☐ **Never:** ☐ **Not in last 12 months:** ☐ **Not in last 5 years:** ☐

Have you recently had any of these breast symptoms:	**Right Breast.**	**Left Breast**
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

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Signature …….. Today's date _____

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): UO____ UI____ LO____ LI____Nipple____

Where (right breast): UO____ UI____ LO____ LI____Nipple____

WOMEN'S HEALTH CONFIDENTIAL QUESTIONNAIRE

NAME: _____DATE OF BITH:_____

Is your menstrual cycle regular? ◯ Yes ◯ No

Do you have heavy bleeding with your menstrual cycle? ◯ Yes ◯ No

Do you have lumps in your breasts that come and go? ◯ Yes ◯ No

Do you experience pre-menstrual headaches? ◯ Yes ◯ No

Do you have low libido? ◯ Yes ◯ No

Do you have hot flashes? ◯ Yes ◯ No

Do you experience mood swings? ◯ Yes ◯ No

Have you ever been diagnosed with endometriosis? ◯ Yes ◯ No

Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)? ◯ Yes ◯ No

Have you ever been treated for infertility? ◯ Yes ◯ No

Have you had difficulty conceiving? ◯ Yes ◯ No

Do you have any swelling in the neck or trouble swallowing? ◯ Yes ◯ No

Have you been diagnosed with any thyroid disorder? ◯ Yes ◯ No

If yes what type: ◯ Hypothyroid ◯ Hyperthyroid ◯ Hashimoto's ◯ Grave's disease

Are you on a thyroid medication or supplement? ◯ Yes ◯ No What kind? _____

Do you regularly experience fatigue? ◯ Yes ◯ No

Have you experienced recent hair loss? ◯ Yes ◯ No

Have you experienced unexplained weight gain? ◯ Yes ◯ No

Have you experienced unexplained weight loss? ◯ Yes ◯ No

Are you intolerant to cooler temperatures/ sensitive to cold? ◯ Yes ◯ No

Do you experience chronic insomnia? ◯ Yes ◯ No

Do you experience chronic brain fog? ◯ Yes ◯ No

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_____ _____

Signature of Patient or Patient's Authorized Representative **Today's Date**