

# Confidential Questionnaire

## *Women's Health Study*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (home) \_\_\_\_\_ (cellular) \_\_\_\_\_ (work) \_\_\_\_\_

E-Mail \_\_\_\_\_ Referring Physician \_\_\_\_\_

*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.*

**Yes    No**

### ***Head & Neck***

- |  |     |     |
|--|-----|-----|
| 1. Do you suffer with headaches?                               | ___ | ___ |
| If yes, once a month or less ___ more than once a month ___    |     |     |
| 2. Do you have known allergies?    Food ___ Environmental ___  | ___ | ___ |
| 3. Do you have TMJ or does your jaw click?                     | ___ | ___ |
| 4. Do you currently have a cold?                               | ___ | ___ |
| 5. Are you being treated for a thyroid disorder?    Type _____ | ___ | ___ |
| 6. Do you have neck pain?                                      | ___ | ___ |
| 7. Do you have upper back pain?                                | ___ | ___ |
| 8. Do you have a known history of carotid artery disease?      | ___ | ___ |
| 9. Do you have a family history of stroke?                     | ___ | ___ |
| 10. Do you currently suffer with sinus problems?               | ___ | ___ |
| 11. Do you have history of dental problems?                    | ___ | ___ |
| Root canals ___ Gum disease ___ Implants ___                   |     |     |
| Non-replaced extractions ___ Dentures ___                      |     |     |
| 12. Have you had dental cleaning in the past 7 days?           | ___ | ___ |

Do you have any special concerns or are there any details related to the information above?

# Breast

Is there a specific reason or concern for this breast exam?

	<b>Yes</b>	<b>No</b>																								
1. Have you recently had any of these breast symptoms? (mark only if “yes”)	___	___																								
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;"></th> <th style="width: 10%; text-align: center;"><b>LT</b></th> <th style="width: 10%; text-align: center;"><b>RT</b></th> <th style="width: 40%;"></th> </tr> </thead> <tbody> <tr> <td>Pain/Tenderness</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Lumps</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Change in breast size</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Areas of skin changes thickening or dimpling</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> <tr> <td>Excretions or changes of the nipple</td> <td style="text-align: center;">___</td> <td style="text-align: center;">___</td> <td></td> </tr> </tbody> </table>		<b>LT</b>	<b>RT</b>		Pain/Tenderness	___	___		Lumps	___	___		Change in breast size	___	___		Areas of skin changes thickening or dimpling	___	___		Excretions or changes of the nipple	___	___			
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2. Are any of the above symptoms cycle related?	___	___																								
3. Are you still having your periods?	___	___																								
4. Have you had a surgical hysterectomy?	___	___																								
If yes, date _____ Complete ___ Partial ___																										
Reason for hysterectomy:																										
<input type="radio"/> Excess bleeding <input type="radio"/> Endometriosis <input type="radio"/> Fibroid cysts <input type="radio"/> Cancer <input type="radio"/> Other																										
5. Has anyone in your family ever been treated for breast cancer?	___	___																								
If yes, note age and survival <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter																										
Age diagnosed _____ Result of Treatment _____																										
6. Have you ever been diagnosed with breast cancer?	___	___																								
If yes, date: _Month _____ Year _____																										
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																										
7. Have you ever been diagnosed with any other breast disease?	___	___																								
If yes: Cysts/fibrocystic ___ Fibro Adenoma ___																										
Mastitis/inflammatory breast disease ___																										
8. Have you had any cosmetic breast surgery or implants?	___	___																								
If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline																										
Experience: <input type="radio"/> Problems <input type="radio"/> No problems																										

**Yes No**

9. Have you ever had any biopsies or any other surgeries to your breasts \_\_\_\_\_
- If yes, date \_\_\_\_\_
- Left breast       Inner                       Outer                       Nipple
- Right breast      Inner                       Outer                       Nipple
- Results             Negative                   Positive                   Calcifications
10. Have you ever taken contraceptive pills for more than one year? \_\_\_\_\_
- If yes,             Currently    Less than 5 years    More than 5 years
11. Have you had pharmaceutical hormone replacement therapy (HRT)? \_\_\_\_\_
- If yes,             Currently    Less than 5 years    More than 5 years
12. Do you have an annual physical examination by a doctor? \_\_\_\_\_
13. Do you perform a monthly breast self exam? \_\_\_\_\_
14. Have you ever smoked? \_\_\_\_\_
15. Have you ever been diagnosed with diabetes? \_\_\_\_\_
16. Total mammograms \_\_\_\_\_
17. Date of last mammogram \_\_\_\_\_ Were you re-called? \_\_\_\_\_
18. Your age at your first mammogram? \_\_\_\_\_
19. Number of full term pregnancies? \_\_\_\_\_
20. Have you had breast ultrasound? \_\_\_\_\_
- If yes...Date: \_\_\_/\_\_\_ Left \_\_\_ Right \_\_\_ Results: Negative \_\_\_ Positive \_\_\_
21. Have you had breast MRI? \_\_\_\_\_
- If yes...Date: \_\_\_/\_\_\_ Left \_\_\_ Right \_\_\_ Results: Negative \_\_\_ Positive \_\_\_

## ***Chest, Heart & Lungs***

**Yes No**

1. Have you been diagnosed with: \_\_\_\_\_
- Heart disease? \_\_\_\_\_
- Lung disease? \_\_\_\_\_
- Upper spine disorders? \_\_\_\_\_
2. Do you suffer with upper back pain? \_\_\_\_\_
3. Do you suffer with chest pain? \_\_\_\_\_
4. Have you ever had surgery to your: \_\_\_\_\_
- Heart? \_\_\_\_\_
- Lungs? \_\_\_\_\_
- Mid to upper back? \_\_\_\_\_
5. Do you have asthma or shortness of breath? \_\_\_\_\_

6. Do you currently smoke? \_\_\_\_\_

7. Have you smoked in the past 5 years? \_\_\_\_\_

Have you consumed alcohol in the past 24 hours? \_\_\_\_\_

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.

**Client 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.

Client Signature \_\_\_\_\_ Today's Date \_\_\_\_\_