LAS VEGAS
THERMOGRAPHY

# FULL BODY STUDY QUESTIONNAIRE

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Patient Name ______________________________ Date of Birth ____________________

Address ______________________________ City ____________________ Zip ________________

Phone ______________________________ Your Doctor ______________________________

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.

**Please Show areas of:**

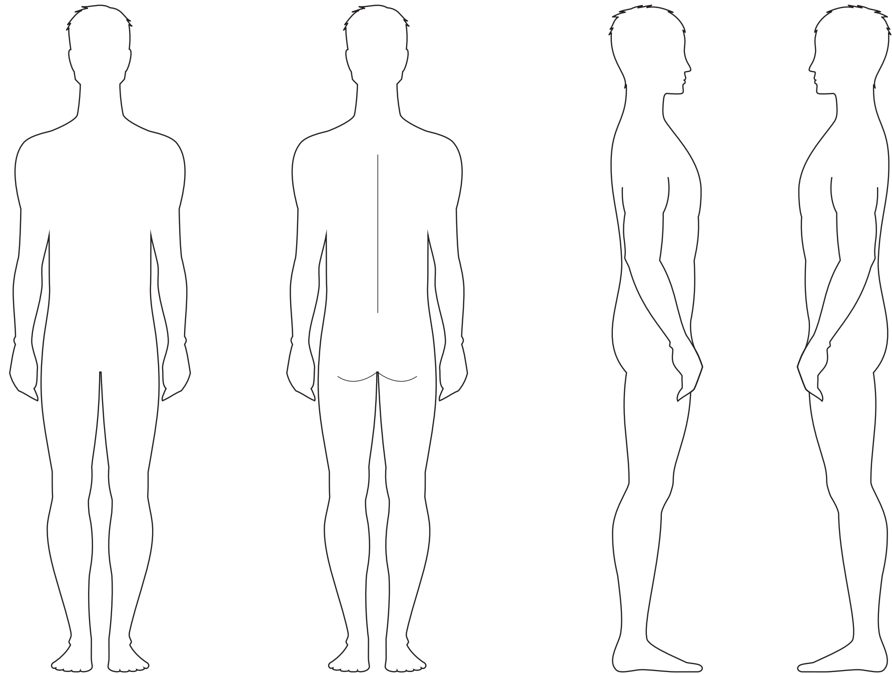
Main Pain *

Secondary Pain Z

Numbness //////////

Pins and needles ::::::::

Skin lesions/scaring ------



Do you know what triggered the pain?
**Yes** ☐ **No** ☐

Does anything relieve it?
**Yes** ☐ **No** ☐

Does anything aggravate it?
**Yes** ☐ **No** ☐

Has it changed since it began?
**Yes** ☐ **No** ☐

Have you had any treatment?
**Yes** ☐ **No** ☐

**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 ______________________________ Date ________________

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Name ______________________________________________ Birthdate ______________________

Address_________________________________ City __________________ Zip ________________

Email _________________________________ Cell Phone _____________ Doctor _____________

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# BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

| | Yes | No |
|---|---|---|
| Do you have any close relative who has had breast cancer? | ☐ | ☐ |
| Have you ever been diagnosed with breast cancer? | ☐ | ☐ |
| Have you ever been diagnosed with any other breast disease (fibrocystic)? | ☐ | ☐ |
| Have you had any biopsies or surgeries to your breasts? | ☐ | ☐ |
| Have you had any breast cosmetic surgery or implants? | ☐ | ☐ |
| Have you had a mammogram in the past 12 months? | ☐ | ☐ |
| Have you had a mammogram in the past 5 years? | ☐ | ☐ |
| Have you had abnormal results from any breast testing? | ☐ | ☐ |
| Have you ever taken a contraceptive pill for more than 1 year? | ☐ | ☐ |
| Have you suffered with cancer of the womb? | ☐ | ☐ |
| Have you had pharmaceutical hormone replacement therapy? | ☐ | ☐ |
| Do you have an annual physical examination by a doctor? | ☐ | ☐ |
| 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? _______ Your age at birth of first child _______

Did your period start before the age of 12? _______ Or finish after the age of 50? _______

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 ______________

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# PATIENT INFORMATION SHEET

Patient Name ______________________________________________

Address ______________________ City ______________ Zip ____________

Date of Birth ____________________ Phone ______________________

Occupation ______________________________________________

Previous Illnesses:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Previous Surgergies:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Current Health Problems:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Medications: ______________________________________________

Other Treatment: ______________________________________________

Do you want a copy of the thermogram report forwarded to your docot? **Yes** ☐ **No** ☐

This information is confidential.

All information is correct to my knowledge

Signature ______________________ Date ____________

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# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name ______________________________________________________________________

Address____________________________________ City ____________________ Zip _________________

Date of Birth _______________________________ Date of Request _______________________________

**As required by the Privacy Regulations, Medithem may not use or disclose your protected health information except as provided in our Notice of Pirvacy Practices without your authorization.**

I hereby authorize the office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office.

## EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail): **Interpretation of said images**

Effective dates for this authorization: ____________________ through ____________________.
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

## I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to thsi autorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provided authorization to use or disclose protected patient health information

Patient Signature ________________________________________ Date _______________

Authorized Signature of Facility ________________________________________ Date _______________