



Name \_\_\_\_\_ Birthdate \_\_\_\_\_

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

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_ 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.

## BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

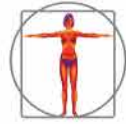
	Yes	No
Do you have any close relative who has had breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with any other breast disease (fibrocystic)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any biopsies or surgeries to your breasts?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any breast cosmetic surgery or implants?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a mammogram in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a mammogram in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had abnormal results from any breast testing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever taken a contraceptive pill for more than 1 year?	<input type="checkbox"/>	<input type="checkbox"/>
Have you suffered with cancer of the womb?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had pharmaceutical hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an annual physical examination by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform a monthly breast self exam?	<input type="checkbox"/>	<input type="checkbox"/>
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 <input type="checkbox"/> Never <input type="checkbox"/> Not in last 12 months <input type="checkbox"/> Not in last 5 years <input type="checkbox"/>		

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

### 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 \_\_\_\_\_



# LAS VEGAS THERMOGRAPHY

## 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 \_\_\_\_\_



# LAS VEGAS THERMOGRAPHY

## PATIENT INFORMATION SHEET

Patient Name \_\_\_\_\_

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

Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Previous Illnesses:

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Previous Surgeries:

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Current Health Problems:

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Medications: \_\_\_\_\_

Other Treatment: \_\_\_\_\_

Do you want a copy of the thermogram report forwarded to your doctor?

**Yes**

**No**

This information is confidential.

All information is correct to my knowledge

Signature \_\_\_\_\_ Date \_\_\_\_\_



## LAS VEGAS THERMOGRAPHY

### 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 Privacy 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 this authorization.
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 \_\_\_\_\_