LAS VEGAS THERMOGRAPHY

Name _____ Birthdate _____

Address _____ City _____ Zip _____

Email _____ Cell Phone _____ Doctor _____

All information given in this 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

Do you have any close relative who has had breast cancer? Yes / No
Have you ever been diagnosed with breast cancer? Yes / No
Have you ever been diagnosed with any other breast disease (fibrocystic)? Yes / No
Have you had any biopsies or surgeries to your breasts? Yes / No
Have you had any breast cosmetic surgery or implants? Yes / No
Have you had a mammogram in the past 12 months? Yes / No
Have you had a mammogram in the past 5 years? Yes / No
Have you had abnormal results from any breast testing? Yes / No
Have you ever taken a contraceptive pill for more than 1 year? Yes / No
How many years have you taken the pill? _____
Have you had pharmaceutical hormone replacement therapy? Yes / No
How many years have you taken hormone replacements? _____
Do you have an annual physical examination by a doctor? Yes / No
Do you perform a monthly breast self exam? Yes / No
What was your age for your first menstrual period? _____
Did your menstrual periods end after age 50? Yes / No
How many mammograms have you had in total? _____
What was your age when you had your first mammogram? _____
What was the date of your last mammogram? _____
What was the result of your last mammogram? _____
Have you given birth to children? Yes / No
How many births have you had? _____
What was your age when you had your first child? _____
Do you smoke? Yes / Never / Not in the last 12 months / Not in the last 5 years

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

PATIENT DISCLOSURE

I understand that the report 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

Name _____ Birthdate _____

Address _____ City _____ Zip _____

Email _____ Cell Phone _____ Doctor _____

Occupation _____

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

PREVIOUS ILLNESSES:

_____

_____

_____

_____

PREVIOUS SURGERIES:

_____

_____

_____

_____

CURRENT HEALTH PROBLEMS:

_____

_____

_____

_____

MEDICATIONS: _____

_____

OTHER TREATMENT(S): _____

_____

Do you want a copy of the thermogram report forwarded to your doctor? Yes / No

If you said yes above, please provide your doctor's email: _____

This information is confidential. All information provided above is correct to my knowledge.

Signature _____ **Today's Date** _____

LAS VEGAS THERMOGRAPHY

Name _____ Birthdate _____

Address _____ City _____ Zip _____

Email _____ Cell Phone _____

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 of 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 renumeration 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 _____ **Today's Date** _____

Authorized Signature of Facility _____ **Today's Date** _____