PICTURE MY HEALTH, LLC

Thermography, the safe way to screen

Breast Thermography Confidential Questionnaire

Name:_____ DOB: _____ PT ID#_____

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
1. Do you have any close relative who has had breast cancer?	☐	☐
If yes, who? _____		
2. Have you ever been diagnosed with breast cancer? ***If yes, see back.***	☐	☐
3. Have you ever been diagnosed with any other breast conditions? ***If yes, see back.***	☐	☐
4. Have you had any biopsies or surgeries to your breasts? ***If yes, see back.***	☐	☐
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 Cervix, Uterus or Ovaries?	☐	☐
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? (a good estimation is ok) _____		
Date of your last mammogram: (mm/yyyy) _____ Were results normal?	☐	☐

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? **YES / NO** Or finish after the age of 50? **YES / NO**

18. Do you smoke? YES / NEVER / NOT IN LAST 12 MONTHS / NOT IN LAST 5 YEARS

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?	☐	☐

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnose 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. In order to obtain an accurate baseline pattern, Picture My Health, LLC requires a three month follow up thermography. The purpose of the three month comparison is to establish the baseline pattern for which all future thermograms are compared to monitor stability. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Disclaimer: Picture My Health, LLC does not claim thermography replaces mammography.

Signature: _____ Today's Date: _____

Extended Breast Questionnaire

Name: _____ DOB: _____ PT ID#:_____

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 ☐

Breast biopsies or surgery:

Where (left breast): UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

Where (right breast): UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

Diagnosed with other breast disease:

Disease type: Fibrocystic ☐ Cystic ☐ Mastitis ☐ Abscess ☐ Other (please describe below) ☐