

Name: \_\_\_\_\_

Today's date: \_\_\_\_\_

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

Pain indicated by a line/ X if numbness indicate N, Scale 1 2 3 4 5 6 7 8 9 10 level of pain 10 is severe pain  
Note : Scars from injuries / surgeries indicate an S and line of scar pattern, moles an M and fractures an F

Arm dominance : left handed      right handed

Which do you suffer from, indicate by circling :

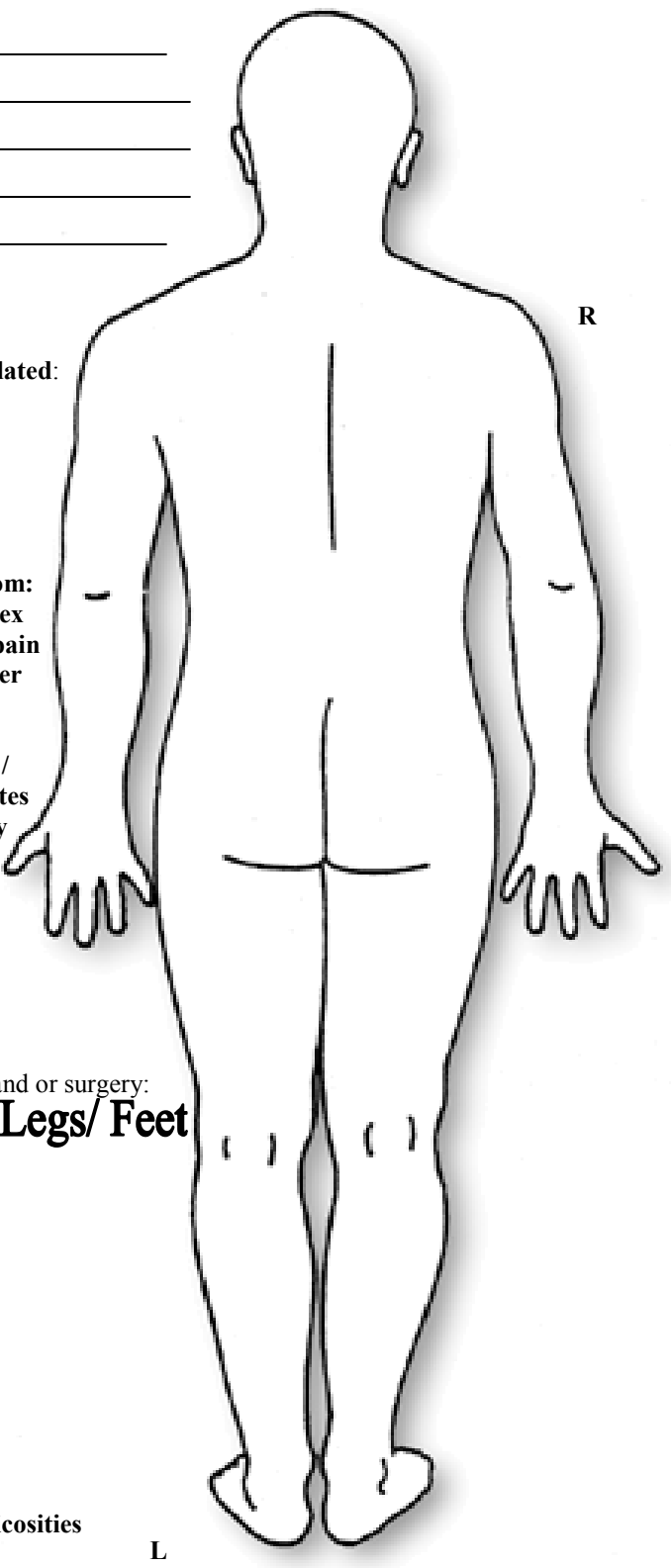
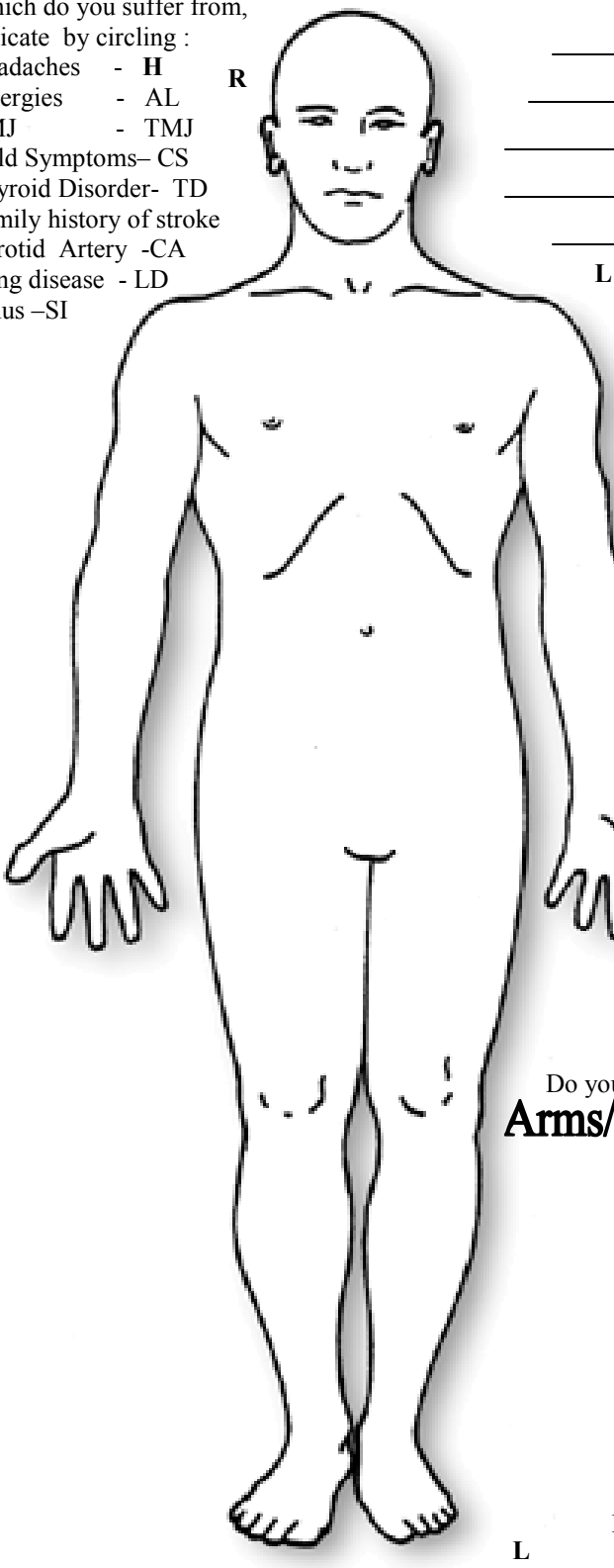
- Headaches - **H**
- Allergies - AL
- TMJ - TMJ
- Cold Symptoms- CS
- Thyroid Disorder- TD
- Family history of stroke
- Carotid Artery -CA
- Lung disease - LD
- Sinus -SI

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



- Surgeries related:**
- Lung
  - Heart
  - Spine
- Suffer from:**
- Acid Reflex
  - Stomach pain
  - Gallbladder
  - Liver
  - Spleen
  - Pancreas /
  - Diabetes
  - Kidney

Do you suffer pain and or surgery:  
**Arms/ Hands/ Legs/ Feet**

Indicate Varicosities

Surgeries related : \_\_\_\_\_

# Thermal Imaging Centers of Louisiana

#225-229-6107 #337-456-7300

When was your last thermal: / /

I was referred by \_\_\_\_\_

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Home Ph. # \_\_\_\_\_ Cell Ph.# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home Ph.# \_\_\_\_\_

Format you desire to receive your report : In person by appointment / Mail / E-Mail

## Breast Questionnaire

(Circle Yes/ No with Clock positions on positive findings)

Room Temperature: start  C  F

end  C  F

1. Do you have any close relative that has breast cancer?  Yes  No

2. Have you ever been diagnosed with breast cancer?  Yes  No

3. Have you ever been diagnosed with any other breast disease?  Yes  No

4. Have you had any biopsies to the breasts and your findings?  Yes  No

If yes, Relationship:

If yes, type Metastatic/ Lymph node/ Local

When:

Where: Right : : Left : :

If yes, findings: fibrocystic / calcium nodule

When:

Where: Right: : Left: :

5. Have you had breast cosmetic surgery or implants?  Yes  No

6. Have you had a mammogram in the last 12 months?  Yes  No

7. Have you had a mammogram in the last 5 years?  Yes  No

8. How many mammograms had you had in total? Total # \_\_\_\_\_

9. At what age did you have your first mammogram? Age # \_\_\_\_\_

10. Have you ever taken a contraceptive pill for more then 1 year?  Yes  No

11. Have you suffered cancer from the womb?  Yes  No

12. Have you had pharmaceutical hormone replacement therapy?  Yes  No

13. Do you have an annual physical examination by a Doctor?  Yes  No

14. Do you perform a monthly breast self examination?  Yes  No

15. How many births have you had? Total# \_\_\_\_\_

16. What was your age when your first child was born? Your Age# \_\_\_\_\_

17. Did your menstrual periods start before the age of 12?  Yes  No

18. Did your menstrual periods stop after the age of 50?  Yes  No

19. Do you smoke? Yes  No  How long? \_\_\_\_\_ Number packs per day? \_\_\_\_\_

20. Have you had any of these breast symptoms in the last 6 months?

Yes No

Pain Y N Left Right Both

Tenderness Y N L R B Previous Illness? \_\_\_\_\_

Lump(s) Y N L R B \_\_\_\_\_

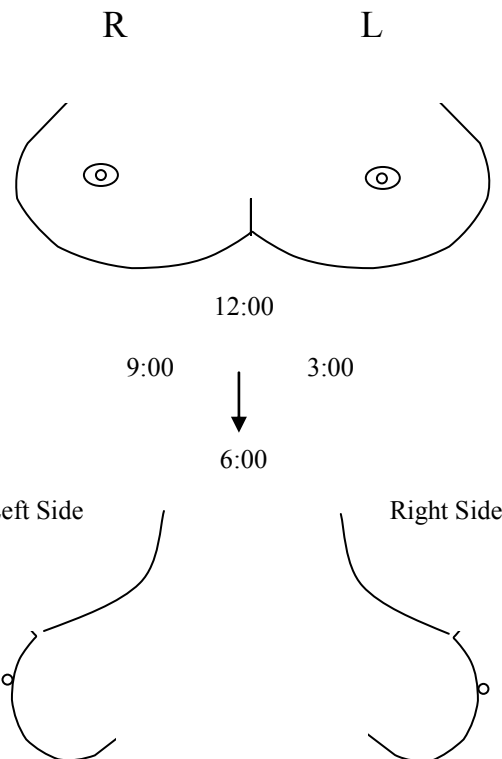
Change in breast size? L R B \_\_\_\_\_

Area of skin thickening or dimpling? L R B Previous surgeries? \_\_\_\_\_

Secretion of the Nipple? L R B \_\_\_\_\_

Current Health Problems? \_\_\_\_\_

Current medications? \_\_\_\_\_



### Patient Disclosure

I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, analysis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis, or treatment. I understand the report will not tell me whether I have an illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Thermal Imaging Centers of LA. And I further authorize direct payment of services to Thermal Imaging Centers of LA.

Patient Signature :

Date : \_\_\_\_\_