

Name: _____ Birth Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Home Ph. # _____ Cell Ph.# _____

Emergency Contact: _____ Home Ph.# _____

Receive your report: Mail / E-Mail _____ Last Thermogram: / /

Breast Questionnaire -

Occupation: _____ I was referred by _____

Have you had the following:

Diagnosed with breast cancer? **Yes / No**

If yes: type- Metastatic / Lymphatic node removal / Local When: / /

Diagnosed of other breast disease? **Yes / No**

Biopsies and your findings? **Yes / No**

Breast surgery/ implants? **Yes / No**

Mammogram last 12 months? **Yes / No**

Total mammograms # _____

First mammogram # _____

Contraceptive over 1 year? **Yes / No**

Hormone therapy? **Yes / No**

Doctors last breast exam? / /

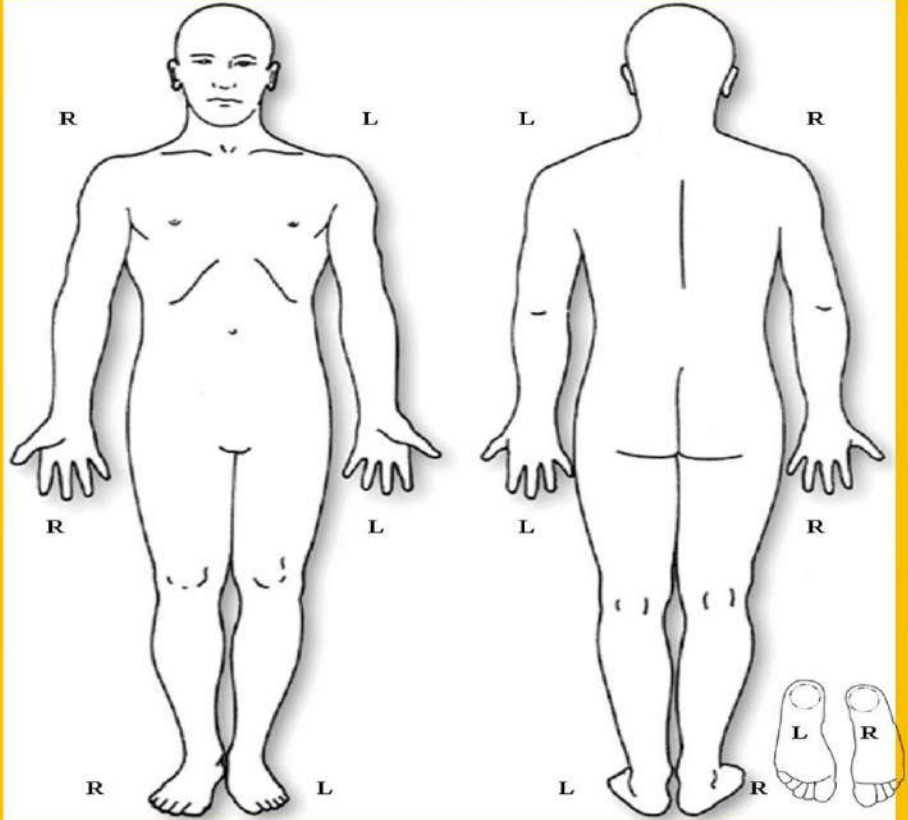
Monthly breast self exams? **Yes / No**

Menstrual periods before 12? **Yes / No**

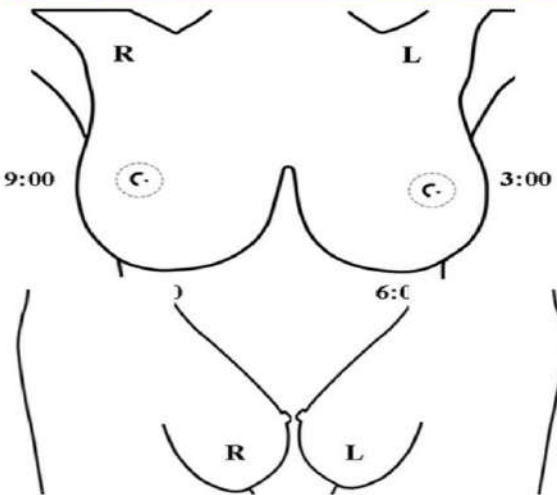
Menstrual stopped after 50 ? **Yes / No**

Total births #? _____, age of first born? _____

Please demonstrate symptoms with the following symbols with accurate locations on the body figure below: "N" for numbness; "1-10" for pain 10 being the worst; "S" for scars; "M" for moles; "F" for fractures; "X" for previous surgeries or current/prior diseases with a line to a brief description.



Breast symptoms in the last 6 months? Please demonstrate symptoms with following symbols: "T" for Tenderness; "L" for Lumps; "D/T" for Nipple Dimpling / Thickening. Change in size "CS"; "NS" Nipple secretion, Biopsy "B".

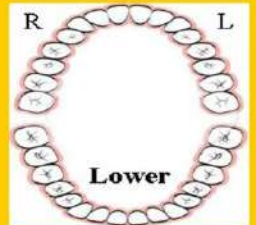


Patient Disclosure

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 of OC, Thermography Unlimited, LLC/Total Thermal Imaging.

Current Issues/Accidents? _____

Current Medications: _____



Teeth/ Gum symbols of history: please use the following letters when marking the areas of the mouth: Root Canal "RC"/Crown "C"/Surgery "S" Mercury Fillings "MF"/ "O" = Other

For Office Use Only: First Visit 3 month 1 YR Recall Super Bill

Description _____ Cost \$ _____

Payment Method: Check# _____ Check / Cash \$ _____

Credit Card Visa MasterCard Discover Exp. Date: _____

Billing Address _____
 SAME AS ABOVE

Patient Signature: _____ Date: _____
 Signature Authorizing Payment