BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE Page 1 of 2

NAME: _____ DATE OF BIRTH: _____

1. Do you have a close relative who has had breast cancer? ◯ Yes ◯ No Relationship: _____

2. Have you ever been diagnosed with breast cancer? ◯ Yes ◯ No - **If NO skip to Question 11**
3. If YES, when: _____
4. Cancer type: ◯ Metastatic ◯ Local ◯ Lymph node involvement
5. Where (Left Breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple
   Where (Right Breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple
6. Treatment: ◯ None ◯ Surgery ◯ Chemotherapy ◯ Radiation
7. If breast radiation treatment – date of last treatment? _____ ◯ Left breast ◯ Right breast
8. Any other treatment? _____
9. Any breast reconstruction after mastectomy? ◯ Yes ◯ No
10. If yes, what type? (ex: trans flap, implant) _____ ◯ Left breast ◯ Right breast

11. Have you ever been diagnosed with any other breast disease? ◯ Yes ◯ No
If YES, what type: ◯ Fibrocystic ◯ Cystic ◯ Mastitis ◯ Dense breast tissue ◯ Abscess Other_____

12. Have you had any biopsies or lumpectomies to your breasts? ◯ Yes ◯ No
Date: _____ Result: ◯ Positive ◯ Negative
Where (Left breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple
Where (Right breast): ◯ Upper/Outer ◯ Upper/Inner ◯ Lower/Outer ◯ Lower/Inner ◯ Nipple

13. Have you had cosmetic breast surgery (implants/ reduction/ lift)? ◯ Yes ◯ No Date:_____

14. Are you currently nursing? ◯ Yes ◯ No

15. Are you currently pregnant? ◯ Yes ◯ No

16. Have you had a mammogram in the past 12 months? ◯ Yes ◯ No Date: _____
Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Inconclusive ◯ Left breast ◯ Right breast
17. Have you had a mammogram in the past 5 years? ◯ Yes ◯ No Approx Date: _____
Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Inconclusive - ◯ Left breast ◯ Right breast

18. Have you had a breast ultrasound in the past 12 months? ◯ Yes ◯ No Date: _____
Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Watchful ◯ Left breast ◯ Right breast
19. Have you had a breast ultrasound in the past 5 years? ◯ Yes ◯ No Approx. Date: _____
Was it: ◯ Normal ◯ Abnormal ◯ Suspicious ◯ Watchful - ◯ Left breast ◯ Right breast

20. Was follow-up biopsy recommended after your most recent mammogram, ultrasound, or MRI? ◯ Yes ◯ No

21. Have you had any abnormal results from any breast testing? ◯ Yes ◯ No
If YES, briefly explain:_____

22. Have you ever taken a contraceptive pill/patch for more than 4 years? ◯ Yes ◯ No

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NAME: _____ DATE OF BIRTH: _____

23. Have you had pharmaceutical hormone replacement therapy? ◯ Yes ◯ No

24. Have you used bio-identical hormone? ◯ Yes ◯ No If yes……. ◯ gel/cream ◯ oral ◯ pellet

25. Have you been diagnosed w/ ovarian, cervical or uterine cancer? ◯ Y ◯ N If yes when?_____

26. Have you had a: ◯ Hysterectomy ◯ Oophorectomy (ovaries) ◯ Total radical hysterectomy

27. Do you have an annual physical breast examination by a doctor? ◯ Yes ◯ No

28. Do you perform a monthly breast self-exam? ◯ Yes ◯ No

29. How many mammograms have you had in total? _____ Have you had more than 30? ◯ Yes ◯ No
30. What was your age when you had your first mammogram? _____

31. How many times have you been pregnant? _____ How many live births? _____
32. What was your age when your first child was born?_____

33. Did you start your period before the age of 12? ◯ Yes ◯ No
34. Are you still having a monthly period? ◯ Yes ◯ No
35. Did your periods finish after the age of 50? ◯ Yes ◯ No

36. Do you smoke? ◯ Yes ◯ Never ◯ Not in last 12 months ◯ Not in last 5 years

37. Have you had a vaccination in the past 4 weeks? If yes, indicate which arm. ◯ Left ◯ Right

38. Have you RECENTLY/ CURRENTLY experienced any of these breast symptoms? (If yes, please mark which breast)

Pain?	◯ Left breast	◯ Right breast
Tenderness?	◯ Left breast	◯ Right breast
Lumps?	◯ Left breast	◯ Right breast
Change in breast size?	◯ Left breast	◯ Right breast
Areas of skin thickening or dimpling?	◯ Left breast	◯ Right breast
Secretions of the nipples?	◯ Left breast	◯ Right breast

If experiencing nipple discharge is it…. ◯ Bloody ◯ Milky ◯ Clear

If nipple retraction: For how many years? ___ ◯ Recently? ◯ Left breast ◯ Right breast

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 & 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 an 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 of Patient or Patient's Authorized Representative **Today's Date**

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