

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? _____ Right breast Left breast
8. Any other treatment? _____
9. Any breast reconstruction after mastectomy? Yes No
10. If yes, what type? (ex: trans flap, implant) _____ Right breast Left 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 - Right breast Left breast
17. Have you had a mammogram in the past 5 years? Yes No Approx Date: _____
Was it: Normal Abnormal Suspicious Inconclusive - Right breast Left breast
18. Have you had an ultrasound in the past 12 months? Yes No Date: _____
Was it: Normal Abnormal Suspicious Watchful - Right breast Left breast
19. Have you had an ultrasound in the past 5 years? Yes No Approx Date: _____
Was it: Normal Abnormal Suspicious Watchful - Right breast Left 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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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 (Uterus+Ovaries+Tubes)
27. Do you have an annual physical 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? _____
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 **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 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