

Patient Information Sheet.

Name ..... D.O.B. ....

Address .....

Phone (H) ..... (W) .....

Occupation .....

Previous Illnesses.

Previous Surgery.

Current Health Problems.

Medication. ....

Other Treatment. ....

Current Doctor. ....

Do you want a copy of the thermogram report forwarded to your doctor ?  
Yes..... No .....

This information is confidential.  
All information is correct to my Knowledge.

Signed ..... Date .....

# **Patient Information:**

## **Breast Screening with Digital Infrared Thermal Imaging (Thermography).**

### **Purpose of test:**

For early detection of abnormal changes in the breasts requiring further diagnostic testing.

### **Patient preparation:**

*Do not smoke for 2 hours before the test*

*Do not use lotions or powder on your breasts or surrounding areas on the day of test*

*Avoid sun exposure on day of test*

*Diet - No changes necessary*

*Medicines - No changes necessary*

Disrobing - Remove all upper body clothing and jewelry. Put on surgical gown supplied. Inform your Thermographer if you have had any recent skin lesions on your breast; the inflammation can cause a false positive result.

### **How the test will feel:**

The number of people involved in the procedure will be limited to protect your privacy.

The room air may feel cool on your breasts as they adjust to room temperature before scanning.

Examining room temperatures are comfortable when you disrobe for the examination.

Any apprehension about the sophisticated thermography equipment is soon dispelled, the procedure is totally non invasive, the camera does not emit radiation of any kind.

### **Time before test results available:**

Time before results are reported to the doctor or patient varies from a few hours to a few days.

### **Frequently asked questions:**

*Who performs test?*

Female Clinical Thermographer.

*Any risks or side effects?*

None. Procedure non-invasive, non-contact, no radiation.

*How long does it take ?*

Patient time for test: 15-20 minutes.

### **You are welcome to bring a companion or partner to be present at the examination**

While participation in a DITI early detection program can increase your chance of detecting and monitoring breast disease, as with all other tests, it is still not a 100% guarantee of detection.

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

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Doctor: \_\_\_\_\_

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.

## Breast Thermography Confidential Questionnaire

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you have any close relative who has had breast cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed with breast cancer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any biopsies or surgeries to your breasts?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any breast cosmetic surgery or implants?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a mammogram in the past 12 months?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a mammogram in the past 5 years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had abnormal results from any breast testing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken a contraceptive pill for more than 1 year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you suffered with cancer of the womb?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had pharmaceutical hormone replacement therapy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have an annual physical examination by a doctor?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you perform a monthly breast self exam?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. How many mammograms have you had in total? _____  |                          |                          |
| 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? _____ Or finish after the age of 50? _____   |                          |                          |
| 18. Do you smoke? Yes: <input type="checkbox"/> Never: <input type="checkbox"/> Not in last 12 months: <input type="checkbox"/> Not in last 5 years: <input type="checkbox"/> |                          |                          |

Have you recently had any of these breast symptoms:	Right Breast.	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

### 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 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.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature ..... Today's date \_\_\_\_\_

## Extended Breast Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### 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\_\_\_\_

### Diagnosed with other breast disease:

**Disease type:** Fibrocystic\_\_\_\_ Cystic\_\_\_\_ Mastitis\_\_\_\_ Abscess\_\_\_\_ Other\_\_\_\_  
(please report other types of disease in the history)

### Breast biopsies or surgery:

**Where (left breast):** UO\_\_\_\_ UI\_\_\_\_ LO\_\_\_\_ LI\_\_\_\_ Nipple\_\_\_\_

**Where (right breast):** UO\_\_\_\_ UI\_\_\_\_ LO\_\_\_\_ LI\_\_\_\_ Nipple\_\_\_\_

# Full Body Study Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

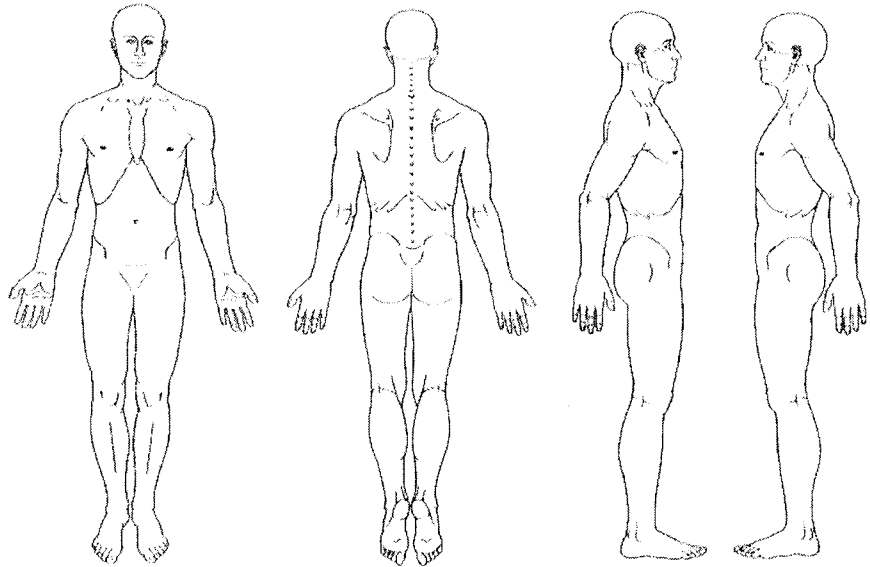
Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Address: \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Your Doctor: \_\_\_\_\_

Please Show areas of :

- Main Pain \*
- Secondary Pain ○
- Numbness //
- Pins and needles :::::
- Skin lesions / scaring



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries / Fractures / Surgery

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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 of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature .....

**Authorization to Use or Disclose Protected Health Information**  
*Medical Thermal Imaging*

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

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**As required by the Privacy Regulations, *Medical Thermal Imaging* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

**EMI, Electronic Medical Interpretations**

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

\_\_\_\_\_

For the specific purpose of (describe in detail)  
**Interpretation of said images**

\_\_\_\_\_

**Effective dates** for this authorization: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_  
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

\_\_\_\_\_  
*Signature or Patient or Patient's Authorized Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Authorized Signature of Facility*

\_\_\_\_\_  
*Date*