Confidential Questionnaire

Breast Health Screening

First Name _____ Middle Initial_____ Last Name _____
Date of Birth ____/___/_____ Age _____
Address_____ City_____ State_____ Zip_____
Home Phone# _____ Work Phone#_____ Cell Phone#_____
Email_____
Please tell us how you heard about Carolina Thermascan_____
Location of scan (please circle):

Raleigh Greensboro Wilmington – Restore Health & Wellness Center Wilmington-ChiroCynergy

Are you a patient at any of any providers at the above locations? Yes____ No ____ If so, we will provide a copy of your report to that practitioner. Name of Provider: _____

Were you referred by another health care practitioner? Yes____ No ____ If so, we will send a copy of your scan and report to that practitioner. Please provide:
_____
_____

CURRENT MEDICATIONS AND SUPPLEMENTS:

Medications: _____
_____
_____
Supplements: _____
_____
_____

Is there a specific reason or concern for this breast exam?

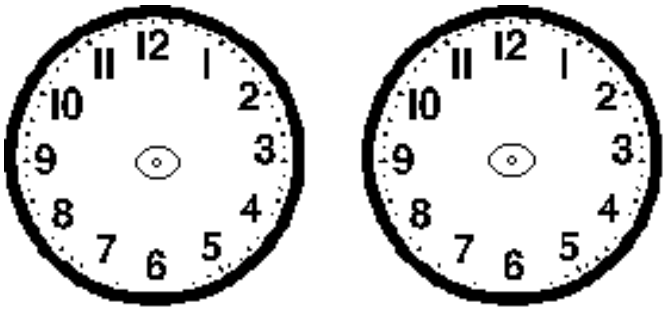
	Yes	No
1. Have you recently had any of these breast symptoms? (mark only if "yes")	___	___

	LT	RT
Pain/Tenderness	___	___
Lumps	___	___
Change in breast size	___	___
Areas of skin changes thickening or dimpling	___	___
Excretions or changes of the nipple	___	___

NOTES:

Indicate by letter on the diagram the region of the breasts if affected by the following:

A Mass **B** Thickening **C** Discharge **D** Nipple Change **E** Skin Change
F Area of Pain **G** Burning **H** Tender **I** Dull Ache **J** Sharp Pain



Right Breast **Left Breast**

2. Are any of the above symptoms cycle related? Yes____ No_____

3. Are you still having your periods? Yes____ No_____

4. Have you had a surgical hysterectomy? Yes____ No_____
   If yes, date_____ Complete __ Partial ___
   Reason for hysterectomy?
   ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? Yes____ No_____
   If yes, note age and survival
   Mother_____Sister_____Daughter_____ Maternal Grandmother____Maternal Aunt___
   Maternal cousin___Paternal Grandmother____Paternal aunt____Paternal cousin____

6. Have you ever had a biopsy? Yes ____ No____ Location: _____ Date:_____ Outcome:_____

7. Have you ever been diagnosed with breast cancer? Yes____ No_____
   If yes, date: Month: _____ Year: _____ Location: _____ Date:_____ Outcome:_____

   Cancer type ○ Local ○ Metastatic ○ Lymph node involvement
   Left breast ○ Inner ○ Outer ○ Nipple
   Right breast ○ Inner ○ Outer ○ Nipple
   Treatment ○ Surgery ○ Chemo ○ Radiation ○ None
   Lumpectomy: Yes _____ No _____ R_____ L _____ Year of Surgery_____
   Mastectomy: Yes _____ No _____ R_____ L _____ Year of Surgery_____
   Breast Reconstruction: Yes _____ No_____R_____ L _____ Year of Surgery_____
   Radiation to the Breast: Yes _____ No_____ R_____ L _____ Year of Treatment_____
   Chemotherapy: Yes _____ No_____ R_____ L _____ Year of Treatment_____
   Breast Augmentation: Yes _____ No_____R_____ L _____ Year of Surgery _____
   Any palpable mass now? Yes _____ No_____R_____ L _____
   Any discharge, inversion or change in nipples? Yes _____ No_____R_____ L _____

8. Have you ever been diagnosed with any other breast disease? Yes____ No_____
   If yes: Cysts/fibrocystic ___ Fibro Adenoma ___
   Mastitis/inflammatory breast disease ___
9. Have you had any cosmetic breast surgery or implants? Yes____ No_____

If yes, date_____ ○ Silicone ○ Saline

Experience: ○ Problems ○ No problems

10. Have you ever had any biopsies or any other surgeries to your breasts Yes____ No_____
If yes, date_____

Left breast	○ Inner	○ Outer	○ Nipple
Right breast	○ Inner	○ Outer	○ Nipple
Results	○ Negative	○ Positive	○ Calcifications

11. Have you ever taken contraceptive pills for more than one year? Yes____ No_____
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

12. Have you had pharmaceutical hormone replacement therapy (HRT)? Yes____ No_____
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

13. Do you have an annual physical examination by a doctor? Yes____ No_____

14. Do you perform a monthly breast self-exam? Yes____ No_____

15. Have you ever smoked? Yes____ No_____

16. Have you ever been diagnosed with diabetes? Yes____ No_____

17. Have you had a mammogram? Yes____ No____ Results: Normal _____ Abnormal____ Suspicious_____

18. Age at first mammogram _____

19. Date of last mammogram _____ Were you re-called? Yes____ No____

20. Have you had breast ultrasound? Yes____ No____
If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___

21. Have you had breast MRI? Yes____ No____
If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___

22. Have you ever undergoing Infrared Thermal Breast Imaging: Yes____ No____
If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination.

Client Signature_____Today's Date_____