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):

Carolina Center Raleigh	Carolina Center Wilmington	Family Functional Medicine Greensboro

Are you a patient 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:____
____
____
____

Allergies:____
____
____
___

Supplements:____
____
____

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

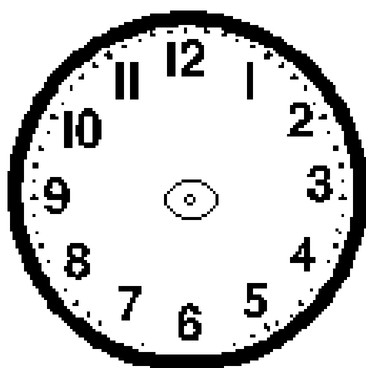
1. Have you recently had any of these breast symptoms? (mark only if "yes")

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

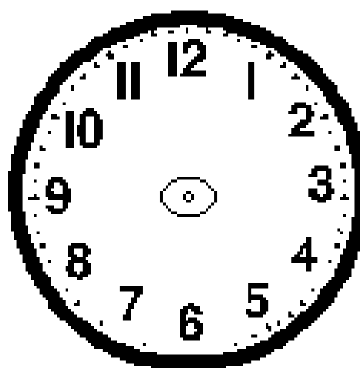
2. When was your last breast exam? ___________ Performed by: (circle):
   Primary Care Gyn Breast Specialist

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

3. Are any of the above symptoms cycle related? Yes____ No______

4. Are you still having your periods? Yes____ No______

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

6. 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____

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 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 called back for a repeat? 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 undergone 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.*

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_______________