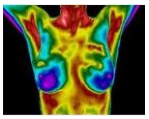


BREAST THERMOGRAPHY
INTAKE FORMS

TIME:
FOR OFFICE USE

Your Age: _____ First Name: _____Last Name: _____Date:_____
Phone: _____Cell Phone: _____ Date of Birth: _____
PHYSICIAN/S:_____
When did your physician or nurse practitioner last examine your breasts? _____
Date of prior Mammograms: _____Results: _____
Date of prior breast MRI: _____ Results: _____
Date of prior Ultrasound: _____ Results: _____
Date of prior Thermogram: _____Results: _____
Your age when you had your first period: _____ Age of menopause: _____
Are you currently pregnant? Y/N Are you currently nursing? Y/N Are you currently taking hormones? Y/N
Have you ever taken hormones? Y / N Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control
What type and for how long? _____
Are you having regular periods? Y / N **Date of last period: _____**

Have you noticed any change/s in your breast/s?

	Right/Left	For how long?
Lump/s	___ / ___	_____
Thickening	___ / ___	_____
Pain	___ / ___	_____
Appearance	___ / ___	_____
Nipple fluid	___ / ___	_____
Other	___ / ___	_____

For assessment of breast cancer risk, please identify your race:
_____ Asian
_____ Black
_____ Caucasian
_____ Hispanic
_____ Other

Has any blood relative had breast cancer?

	Yes / No	Her age when diagnosed:
Mother	___ / ___	_____
Sister	___ / ___	_____
Daughter	___ / ___	_____
Other	___ / ___	_____

Please complete the <u>dates</u> for any of the following procedures or problems you have had:

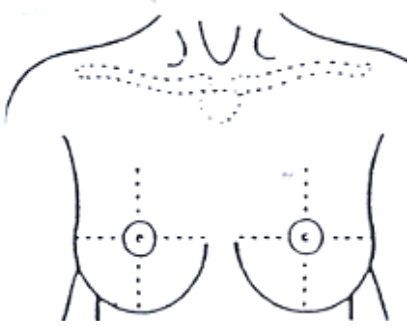
	Right/Left	Date:		Right/Left	Date:
Breast Reduction	____/____	_____	Surgical Breast Biopsy	____/____	_____
Breast Reconstruction	____/____	_____	Needle Biopsy	____/____	_____
Silicone Injections	____/____	_____	Lumpectomy for Cancer	____/____	_____
Breast Implants	____/____	_____	Radiation Therapy	____/___	_____
Implants Replaced	____/____	_____	Mastectomy	____/____	_____
Mastitis/Abscess	____/____	_____	Cyst Aspiration	____/____	_____
Radiation Treatment (Chest/Neck)	____/____	_____	Injury to Breast	____/____	_____

I understand that I will be responsible for payment at the time of services rendered.

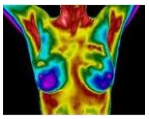
Patient Signature: _____ Date: _____

Notes:

Right



Left



BREAST THERMOGRAPHY
INTAKE FORMS

Name _____ Age: _____

Today's Date: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: HOME: _____

CELL: _____

Who Referred You to our Practice? _____

REPORTS ARE SENT TO CLIENTS VIA EMAIL

E-mail Address: _____

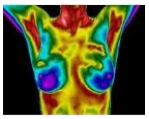
I understand that the risk assessment evaluation report generated from my images are intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the report does not provide diagnosis of disease, eliminate the possibly that disease is present and that the report is not intended for self diagnosis or self evaluation.

Payment is due at time of services rendered.

Patient Signature: _____ Date: _____

Optional: I give consent to the anonymous use of my Thermal Images and data for continued research and development of Thermal Breast Health imaging technology.

Patient Signature: _____ Date: _____



BREAST THERMOGRAPHY
INTAKE FORMS

Thermal Imaging Protocols and Consent

Please check any related items for the evaluating doctor's consideration.

You cannot be sunburned or have a fever at the time of your examination.

If you are wearing deodorant, please wipe it off before acclimating.

- o Did you have chiropractic care, physical therapy or massage therapy today?
- o Have you used analgesic creams, balms, magnets or poultice in the last 24 hours?
- o Did you consume caffeine or nicotine within 4 hours of your examination?
- o Did you shave under your arms in the last 24 hours?
- o Did you apply creams, lotions, talcum powder or skin products on your upper torso today?
- o Have you exercised within the last 4 hours?
- o Please inform us if you have had radiation treatment within the last 6 months.

Thermography of the breasts is a procedure utilizing computerized thermal imaging cameras to visualize and obtain an image of the heat coming from the surface of the skin. The thermographic procedure is performed as an aid to the evaluation of abnormal temperature patterns of the breast which may or may not indicate the presence of a disease process.

Thermography is NOT a standalone diagnostic tool. It is an adjunctive tool, which while reliable, should be used by the primary care physician along with other diagnostic tests and analysis so as to arrive at a provisional or more complete diagnosis. No surgical procedure should be based on breast thermal imaging alone. Physical examination, mammography, ultrasound, palpation, MRI, biopsy, blood test, etc. are needed to arrive at a final diagnosis.

I understand that I will be disrobed from the waist up to allow the surface of my body to cool to an ambient room temperature. This procedure does not use radiation, compression, and it has no known risks or side effects.

The information provided will be made available to my personal physician or others as I so designate for further diagnosis and analysis in the overall evaluation of my breast health. I have been given preparation protocols to insure the most accurate thermographic evaluation of my breasts possible and I agree that I have completed the requirements.

I certify that I have complied with the above protocols and preparation instructions and/or that I have noted any protocol(s) I was unable to comply with so that a decision can be made as to whether or not I can have thermographic imaging on the day scheduled.

I understand that Thermography is not a standalone screening.

Having received satisfactory answers to all questions, I consent to the thermographic examination.

Patient's Signature_____ Date: _____

Print Patient's Name _____