THERMOGRAPHY OF HOUSTON
See Yourself in a New Way!

FOR OFFICE USE ONLY

Pt ID #: _____ Rpt #: _____

BR1 WW HB FB ROI - URGENT - INV

EM-C (PW: text / call) - M-C / M-D - LOC:_____

Patient Information Sheet

Name _____ Date _____

Address _____ Ph _____

City, State, Zip _____ Alt Ph _____

Please place a check mark by the phone number you are most likely to answer during regular office hours.

Occupation _____ Age _____

Email Address _____

Reason for Thermal Scan _____

Current Health Concerns _____

Troublesome Symptoms _____

What Aggravates Them/Relieves Them _____

Current Doctor and Type _____

Medication Currently Taking _____

Other Treatment For This Condition _____

Previous Illnesses and When _____

Previous Surgery and When _____

Anything else you think is important for us to know? _____

_____

How would you like to receive your report? (Circle one) Email to Me Mail to Me Mail to My Doctor*

** If mailing to your doctor, please provide the following:*

Doctor's Name _____ Doctor's Phone # _____

Doctor's Address _____

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

Signed _____ Date _____

Printed Name _____

BREAST QUESTIONNAIRE

Name _____ Date of Birth _____

Referred By _____ Primary 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.

	Yes	No
1. Do you have any close relative who has had breast cancer?	❑	❑
2. Have you ever been diagnosed with breast cancer?	❑	❑
3. Have you ever been diagnosed with any other breast disease?	❑	❑
4. Have you had any biopsies or surgeries to your breasts?	❑	❑
5. Have you had any cosmetic surgery or implants?	❑	❑
6. Have you had a mammogram in the past 12 months?	❑	❑
7. Have you had a mammogram in the past 5 years?	❑	❑
8. Have you had abnormal results from any breast testing?	❑	❑
9. Have you ever taken a contraceptive pill for more than 1 year?	❑	❑
10. Have you suffered with cancer of the womb?	❑	❑
11. Have you had pharmaceutical hormone replacement therapy?	❑	❑
12. Do you have an annual physical examination by a doctor?	❑	❑
13. Do you perform a monthly breast self-exam?	❑	❑

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 the birth of your first child _____
17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____
18. Do you smoke? ❑ Yes ❑ Never ❑ Not in the last 12 months ❑ Not in the last 5 years (or more)

Have you recently had any of these breast symptoms?

	Right Breast	Left Breast
Pain	❑	❑
Tenderness	❑	❑
Lumps	❑	❑
Change in breast size	❑	❑
Areas of skin thickening or dimpling	❑	❑
Secretions of the nipple	❑	❑

MEDICAL INFRARED THERMOGRAPHY

Breast, Hormone, General and Family History

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.

Please circle Y for Yes and N for No on the following questions:

Y N Do you have a family history of breast conditions?

❑ Self ❑ Mother ❑ Grandmother ❑ Sister ❑ Daughter ❑ None

List the condition(s): _____

Y N Do you have any diagnosed breast conditions? If yes, date _____

❑ Cysts ❑ Fibrocystic ❑ Mastitis ❑ Fibro Adenoma ❑ Cancer ❑ Other: _____

If cancer, was it ❑ Local ❑ Metastatic ❑ Involving a Lymph Node

If in the Left Breast, where? ❑ Upper Inner ❑ Lower Inner ❑ Upper Outer ❑ Lower Outer ❑ Nipple

If in the Right Breast, where? ❑ Upper Inner ❑ Lower Inner ❑ Upper Outer ❑ Lower Outer ❑ Nipple

What treatment was used? ❑ Surgery ❑ Chemo ❑ Radiation ❑ Other: _____

Y N Have you previously had a thermogram? Date of most recent _____

Was it: ❑ Normal ❑ Abnormal ❑ Suspicious ❑ Being Watched Which Breast? ❑ R ❑ L

Y N Have you previously had a mammogram? Date of most recent _____

Was it: ❑ Normal ❑ Abnormal ❑ Suspicious ❑ Being Watched Which Breast? ❑ R ❑ L

Y N Have you had an ultrasound? Date of most recent _____

Was it: ❑ Normal ❑ Abnormal ❑ Suspicious ❑ Being Watched Which Breast? ❑ R ❑ L

Y N Have you had a breast exam by a doctor? Date of most recent _____

Was it: ❑ Normal ❑ Lump Found Which Breast? ❑ R ❑ L

Y N Have you had any biopsies? If so, include dates _____

and what types (i.e. needle, excisional) _____

Left Breast ❑ Upper Inner ❑ Upper Outer ❑ Lower Inner ❑ Lower Outer ❑ Nipple

Right Breast ❑ Upper Inner ❑ Upper Outer ❑ Lower Inner ❑ Lower Outer ❑ Nipple

Results ❑ Negative ❑ Positive ❑ Calcifications

Breast and Hormone History

Please circle Y for Yes and N for No on the following questions:

Y N Have you had any cosmetic breast surgery or implants? If so, when? _____ ❑ R ❑ L Breast
❑ Silicone ❑ Saline Were there problems? ❑ Y ❑ N
If yes, list: _____

Y N Have you had a mastectomy? If yes, when? _____ Which Breast? ❑ R ❑ L
❑ Complete ❑ Partial ❑ Type of breast reconstruction _____
Was the nipple removed? ❑ Y ❑ N

Y N Have you had radiation as cancer treatment? If so, when was it performed and where? _____
Was it: ❑ Normal ❑ Abnormal ❑ Suspicious ❑ Being Watched Which Breast? ❑ R ❑ L

Y N Have you had a hysterectomy? If so, at what age? _____ ❑ Complete ❑ Partial
For what reason? ❑ Excess bleeding ❑ Endometriosis ❑ Fibroid cysts ❑ Cancer ❑ Other

Y N Are you currently pregnant?

Y N With any previous births, how long did you breastfeed each child? _____
Are you currently nursing? ❑ Yes ❑ No

Y N Are you still having periods?

Y N Are you currently taking birth control? If yes, at what age did you start? _____ For how many years? _____

Y N Are you in menopause? If so, what age did it begin? _____

Y N Have you ever taken synthetic hormone replacement (for example, Premarin, Prempro, or Provera)?
If so, how many years did you take it? _____

Y N Have you ever taken pharmaceutical hormone replacement (like bioidentical hormones)?
If so, how many years did you take it? _____

Y N Are you currently using natural progesterone cream? If so, for how long? _____
Applied to: ❑ Breasts only ❑ Rotating body areas

Y N Are you currently using any herbals, homeopathics, or supplements to stimulate or simulate estrogen?
Explain _____

Y N Do you feel that you are overweight? If yes, how many pounds overweight? _____
Have you lost any weight recently? If yes, how many pounds? _____

Y N Do you have any medical conditions or diagnoses? _____
_____

Current Breast Symptoms

Are you currently experiencing any of the following with your breasts?

Please circle Y for Yes and N for No on the following questions:

Y N A lump. Date found _____ ..... ❑ R Breast ❑ L Breast
Discovered by ❑ Self ❑ Doctor ❑ Other
It is: ❑ Hard ❑ Soft ❑ Mobile ❑ Tender

Y N Pain ..... ❑ R Breast ❑ L Breast
It is: ❑ Dull ❑ Sharp ❑ Burning ❑ Stinging ❑ Tender ❑ Changes with my cycle / monthly hormones

Y N Thickening ..... ❑ R Breast ❑ L Breast

Y N Skin changes: ❑ Color ❑ Texture ❑ Over the lump ..... ❑ R Breast ❑ L Breast

Y N Nipple discharge ..... ❑ R Breast ❑ L Breast
It is: ❑ Bloody ❑ Milky ❑ Through one duct ❑ Through multiple ducts

Y N Nipple retraction ..... ❑ R Breast ❑ L Breast

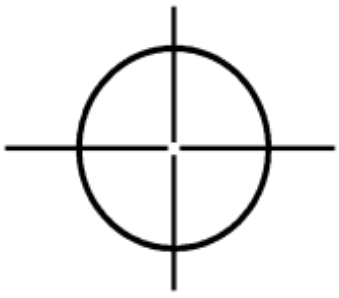
Y N Nipple changes ..... ❑ R Breast ❑ L Breast
Changes in: ❑ Color ❑ Texture

Y N Change in breast size ..... ❑ R Breast ❑ L Breast
❑ Larger ❑ Smaller ❑ Changes with my cycle / monthly hormones

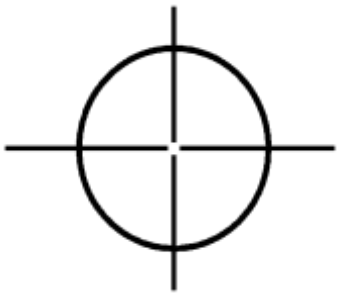
Y N Other? _____

Y N Any of the above symptoms related to your menstrual cycle? If yes, how? _____

Place an [O] on the diagram in the exact area of the lump, a finding on your mammogram, or an area being watched. Place an [X] in the area of pain, tenderness, thickening, or skin changes.



RIGHT BREAST



LEFT BREAST

Please note any other concerns/issues you may have: _____

General Health Information

Please circle all of the conditions you have had in the past or currently have:

Abscesses	Diabetes	Herpes	Pelvic Inflammatory Disease	Sinusitis
Addiction	Emphysema	Influenza	Peritonitis	Sunstroke
Allergies	Epilepsy	Kidney Disease	Pleurisy	Stroke
Amnesia	Gallstones	Leukemia	Pneumonia	Syphilis
Arthritis	Goiter	Malaria	Prostatitis	Tuberculosis
Asthma	Gonorrhea	Measles	Rheumatic Fever	Typhoid Fever
Cancer	Gout	Miscarriage	Rubella	Venereal Warts
Chicken Pox	Hay Fever	Mononucleosis	Scarlet Fever	Warts
Cold Sores	Heart Disease	Mumps	Skin Disease	Whooping Cough
Depression	Hepatits	Parasites	Strep Throat	Yellow Fever

Others _____

Y N Are there any of the above conditions after which you have never been totally well again, or which have been more severe than usual? Explain _____

Y N Have you had any operations? If so, what type and when? _____

_____

Y N Have you had any major injuries? If so, what type and when? _____

_____

Y N Do you exercise? If so, how often? _____

Y N Are you taking any of the following? List how much -

Alcohol _____ Tobacco _____

Caffeine *(coffee, tea, chocolate)* _____ Recreational Drugs _____

Please circle all of the following conditions that have affected your relatives:

Alcoholism	Asthma	Diabetes	Paralysis	Stroke
Allergies	Cancer	Epilepsy	Pneumonia	Syphilis
Arthritis	Depression	Gonorrhea	Skin Disease	Tuberculosis

FAMILY HISTORY	Age if Alive	Age at Death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

UPPER BODY QUESTIONNAIRE

Please circle Y for Yes and N for No on the following questions:

HEAD & NECK

Y N Do you suffer with headaches? If yes, how often: _____

Y N Do you have allergies? If yes, to what? _____

Y N Do you have: ❑ TMJ OR ❑ Jaw clicks when chewing

Y N Do you currently have a cold?

Y N Are you being treated for a thyroid disorder? If yes, how? _____

Y N Do you have neck pain? If yes, describe _____

Y N Do you have a history of carotid artery disease?

Y N Do you have a family history of stroke?

Y N Do you currently suffer with sinus problems?

Y N Do you have any dental crowns/caps, root canals, metal amalgams, or dental implants? If yes, list where these are in your mouth: _____

Y N Do you have: ❑ Gum disease ❑ Receding/bleeding gums

BREAST & CHEST

Y N Have you ever been diagnosed with: ❑ Heart Disease

If yes, please list diagnosis: _____

Y N Do you suffer with chest pain? If yes, describe _____

Y N Have you ever had surgery in the following area: ❑ Heart

Y N Do you have any special concerns or details related to the information given above? If so, please list _____

_____

BACK

Y N Do you have pain in the following areas:

❑ Upper Back ❑ Lower Back

If yes, describe pain(s) _____

Y N Do you have: ❑ Asthma OR ❑ Shortness of breath

Y N Do you currently smoke?

Y N Have you smoked in the last 5 years?

Y N Have you ever been diagnosed with: ❑Lung Disease ❑Mid to Upper Spine Disorders

If yes, please list diagnosis:_____

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

❑ Lungs ❑ Mid to Upper Back ❑ Lower Back ❑ Kidneys

If yes, list surgery/condition & when _____

Y N Do you have any special concerns or details related to the information given above? If so, please list _____

_____

UPPER BODY QUESTIONNAIRE, Cont'd...

ABDOMEN

Y N Do you suffer with acid reflux? If yes, how often_____

Y N Do you have pain in the following areas:

❑ Stomach ❑ Abdomen (upper/lower) ❑ Below Right Breast

If yes, describe pain(s)_____

Y N Have you had surgery or suffered with a condition (infection, etc.) in the following?:

❑ Stomach ❑ Spleen (upper left) ❑ Liver (upper right) ❑ Intestines ❑ Abdomen

If yes, list surgery/condition and when:_____

Y N Do you have any special concerns or details related to the information given above? If so, please list: _____

_____

UPPER EXTREMITIES

Y N Do you have pain in the following? If yes, describe pain(s) _____

❑ Shoulder Rt Lt ❑ Elbow Rt Lt

❑ Arm Rt Lt ❑ Hands Rt Lt

If yes, describe pain(s) _____

Y N Have you had surgery or suffered with a condition (tear, broken bone, etc.) in the following?:

❑ Shoulder Rt Lt ❑ Elbow Rt Lt

❑ Arm Rt Lt ❑ Hands Rt Lt

If yes, list surgery/condition & when _____

Y N Do you have any special concerns or details related to the information given above? If so, please list _____

_____

INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- Thermography of Houston and its staff of certified thermographers will use Digital Infrared Thermal Imaging (DITI) to take images of specified region(s) of my body as requested.
- These images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
- My images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) Inc. (thermology group). The Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.
- DITI is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
- The Report will not tell me whether I have any illness, disease or condition, but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.
- DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI).
- I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore I hold Thermography of Houston harmless as to the results and interpretations resulting from this process.
- Thermography of Houston will keep all information shared by me completely confidential unless I provide a release in writing or as required by law (HIPAA).

Acknowledgement

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

_____

Name (please print) Date Date of Birth

_____

Client Signature

_____

Name, if other than client, and relationship to client

Authorization to Use or Disclose Protected Health Information

Thermography of Houston

Patient Name**:** _____

Address: _____

Date of Birth: _____ Date of Request**:** _____

As required by the Privacy Regulations, *Thermography of Houston* **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: _____
This authorization will expire upon written request.

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*