New England Clinical Thermography

Breast Thermography Confidential Questionnaire

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

Name: _____MI: ____ Birth date: _____
Address: _____City _____ State ____Zip _____
Phone:_____ Doctor:_____

	Yes	No
1. Do you have any close relative who has had breast cancer?	___	___
If yes, which relative?_____		
2. Have you ever been diagnosed with breast cancer?	___	___
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	___	___
4. Have you had any biopsies or surgeries to your breasts?	___	___
<u>If you answer yes to any of questions 2, 3 or 4 you must complete page 2!!!</u>		
5. Have you had any breast 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 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? (Circle) Yes Never Not in last 12 months Not in last 5 years

Have you <u>recently</u> 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	____	____

<u>If you have any of the above symptoms, see page 2</u>

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: _____ Local_____ Lymph node involvement_____
When diagnosed: Month_____ Year_____

Where:	**left breast**	**right breast**
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

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: (indicate which)

Where:	**left breast**	**right breast**
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

Dates of biopsies/surgery

_____

_____

Result of biopsies/surgery_____

_____

Recent breast symptoms: Are they menstrual cycle related? Yes No (circle)
If not, how recently did they develop? _____

Any other comments on breast symptoms: _____

_____