Proactive Health Solutions, LLC

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

NAME _____ DATE OF BIRTH _____

	YES	NO
• Do you have any close relative who has had breast cancer?	○	○
• Have you ever been diagnosed with breast cancer?	○	○

If YES, when: Month _____ Year _____
Cancer type: ○ Metastatic ○ Local ○ Lymph node involvement
Where (Left breast): ○ UO ○ UI ○ LO ○ LI ○ Nipple
Where (Right breast): ○ UO ○ UI ○ LO ○ LI ○ Nipple
Treatment: ○ None ○ Surgery ○ Chemo ○ Radiation ○ Other

• Have you every been diagnosed with any other breast disease?	○	○

If YES, disease type: ○ Fibrocystic ○ Cystic ○ Mastitis ○ Abscess ○ Other _____

• Have you had any biopsies/lumpectomy to your breasts?	○	○

Date: _____ Result: ○ Positive ○ Negative
Where (Left breast): ○ UO ○ UI ○ LO ○ LI ○ Nipple
Where (Right breast): ○ UO ○ UI ○ LO ○ LI ○ Nipple

• Have you had any breast cosmetic surgery or implants?	○	○

Date: _____

• Have you had a mammogram in the past 12 months?	○	○

Date: _____ Result: ○ Positive ○ Negative

• Have you had a mammogram in the past 5 years?	○	○

Approx. date: _____

• Have you had any abnormal results from any breast testing?	○	○

If YES, briefly explain: _____

• Have you ever taken a contraceptive pill/patch for more than 1 year?	○	○
• Have you been diagnosed with cervical or uterine cancer?	○	○
• Have you had pharmaceutical hormone replacement therapy?	○	○
• Do you have an annual physical examination by a doctor?	○	○
• Do you perform a monthly breast self-exam?	○	○

- How many mammograms have you had in total? _____
- What was your age when you had your first mammogram? _____
- How many births have you had? _____ • What was your age at the birth of your first child? _____

• Did your period start before the age of 12?	○	○
• Did your period finish after the age 50?	○	○

- Do you smoke? ○ Yes ○ Never ○ Not in last 12 mo. ○ Not in last 5 or more years
- Have you recently / currently experienced these breast symptoms:

	Right	Left
Pain	○	○
Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin thickening or dimpling	○	○
Secretions of the nipples	○	○

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 & 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 & understand the statements above and consent to the examination.*

Signature of Patient or Patient's Authorized Representative _____ Today's Date _____