The Thermography Center
A Division of Radiant Health, Inc.

Confidential Questionnaire for Women's Health Check

NAME_____Date of Birth_____

Please mark YES or NO as it applies to you:	YES	NO
Any close relative ever had breast cancer?		
Ever been diagnosed with breast cancer? Left 5 Right 5 Date:		
Diagnosed with any other breast disease? (Fibrocystic, Mastitis, Cystic, Abscess)		
Any biopsy or surgery to your breasts? Left 5 Right 5 Date:		
Cosmetic surgery to breasts? (implants, reduction, lift) Left 5 Right 5 Date:		
Do you have dense breast tissue?		
Have you had a mammogram in the past 12 months?		
Have you had more than 30 mammograms in your lifetime?		
Mammogram in the past 5 years? Date of most recent mammo or U/S:		
Any abnormal results from any breast testing?		
Ever taken a contraceptive pill for more than 4 years? How long?		
Ever diagnosed with ovarian, uterine or cervical cancer?		
Ever taken hormone replacement therapy? (pharmaceutical or bio-identical)		
Do you have an annual physical breast examination by a doctor?		
Do you perform a monthly breast self-exam?		
Did your periods start before the age of 12?		
Did your periods end after the age 50?		
Are you still having a menstrual cycle?		
Have you ever given birth to a child?		
Have you ever smoked for more than 5 years?		
Is your menstrual cycle irregular?		
Do you experience cramping during your menstrual cycle?		
Do you have heavy bleeding with your menstrual cycle?		
Do you have breast pain or tenderness that comes and goes?		
Do you have any breast lumps that come and go?		
Do you have low libido? (low sex drive)		
Do you have hot flashes?		

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Please mark YES or NO as it applies to you	YES	NO
Have you ever been diagnosed with endometriosis?		
Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)?		
Have you ever been treated for infertility?		
Do you have any swelling in the neck or trouble swallowing?		
Any thyroid disorder? (hypothyroid/ hyperthyroid/ Hashimoto's/ Grave's disease)		
Do you regularly experience fatigue?		
Have you experienced recent hair loss?		

Have you recently had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	Right Breast	Left Breast
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Have you had any type of Vaccination in last 4 weeks? LEFT ARM ☐ RIGHT ARM ☐ NO☐

PATIENT DISCLOSURE:

I understand that the Report generated from my images is intended for use by trained healthcare 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 _____ Date_____