



*The Thermography Center*  
*A Division of Radiant Health, Inc.*

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Doctor: \_\_\_\_\_

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

### Confidential Breast Thermography Questionnaire

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Do you have any close relatives who have had breast cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been diagnosed with breast cancer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any biopsies or surgeries to your breasts?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you had any breast cosmetic surgery or implants?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a mammogram in the past 12 months?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a mammogram in the past 5 years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had abnormal results from any breast testing?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever taken a contraceptive pill for more than 1 year?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you suffered with cancer of the womb?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had pharmaceutical hormone replacement therapy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have an annual physical examination by a doctor?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you perform a monthly breast self-exam?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? Yes: <input type="checkbox"/> Never: <input type="checkbox"/> Not in last 12 months: <input type="checkbox"/> Not in last 5 years: <input type="checkbox"/> |                          |                          |

Have you recently had any of these symptoms:	Right Breast	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

#### 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.

[www.TheThermographyCenter.com](http://www.TheThermographyCenter.com)

(805) 560-7602



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Signature : \_\_\_\_\_ Today's Date: \_\_\_\_\_