# Confidential Questionnaire

# *Breast*

Name_____ Birth Date_____ Today's Date_____
Address_____ City_____ State_____ Zip_____
Phone Number Home_____ Cellular_____ Work_____
E-Mail Address_____
Referring Physician_____

Is there a specific reason or concern for this exam?

| | | | Yes | No |
|---|---|---|---|---|
| 1. | Have you recently had any of these breast symptoms? (mark only if "yes") | | ○ | ○ |
| | | **LT** **RT** | | |
| | Pain/Tenderness | ○ ○ | | |
| | Lumps | ○ ○ | | |
| | Change in breast size | ○ ○ | | |
| | Areas of skin changes thickening or dimpling | ○ ○ | | |
| | Excretions or changes of the nipple | ○ ○ | | |
| 2. | Are any of the above symptoms cycle related? | | ○ | ○ |
| 3. | Are you still having your periods? | | ○ | ○ |
| | If yes, date of last period_____ | | | |
| 4. | Have you had a surgical hysterectomy? | | ○ | ○ |
| | If yes, date_____ ○ Complete ○ Partial | | | |
| | Reason for hysterectomy? | | | |
| | ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other | | | |
| 5. | Has anyone in your family ever been treated for breast cancer? | | ○ | ○ |
| | If yes, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter | | | |
| | Age diagnosed _____ Result of Treatment_____ | | | |
| 6. | Have you ever been diagnosed with breast cancer? | | ○ | ○ |
| | If yes, date Month_____ Year_____ | | | |
| | Cancer type ○ Local ○ Metastatic ○ Lymph node involvement | | | |
| | Left breast ○ Inner ○ Outer ○ Nipple | | | |
| | Right breast ○ Inner ○ Outer ○ Nipple | | | |
| | Treatment ○ Surgery ○ Chemo ○ Radiation ○ None | | | |
| 7. | Have you ever been diagnosed with any other breast disease? | | ○ | ○ |
| | If yes, ○ Cysts/fibrocystic ○ Fibro Adenoma ○ Mastitis/inflammatory breast disease | | | |
| 8. | Have you had any cosmetic breast surgery or implants? | | ○ | ○ |
| | If yes, date_____ ○ Silicone ○ Saline | | | |
| | Experience: ○ Problems ○ No problems | | | |

| | Yes | No |
|---|---|---|
| 9. Have you ever had any biopsies or any other surgeries to your breasts | O | O |
| If yes, date_____ | | |
| Left breast O Inner O Outer O Nipple | | |
| Right breast O Inner O Outer O Nipple | | |
| Results O Negative O Positive O Calcifications | | |
| 10. Have you ever taken contraceptive pills for more than one year? | O | O |
| If yes, O Currently O Less than 5 years O More than 5 years | | |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)? | O | O |
| If yes, O Currently O Less than 5 years O More than 5 years | | |
| 12. Do you have an annual physical examination by a doctor? | O | O |
| 13. Do you perform a monthly breast self exam? | O | O |
| 14. Have you ever smoked? | O | O |
| 15. Have you ever been diagnosed with diabetes? | O | O |
| 16. Total mammograms____ | | |
| 17. Date of last mammogram _____ Were you re-called? | O | O |
| 18. Your age at your first mammogram?_____ | | |
| 19. Number of full term pregnancies?_____ | | |
| 20. Have you had breast ultrasound? | O | O |
| If yes...Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____ | | |
| 21. Have you had breast MRI? | O | O |
| If yes...Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____ | | |

Do you have any special concerns or are there any details related to the information above?

***Procedure:*** *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

***Patient Disclosure:*** *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination.*

Patient Signature_____Today's Date_____

# The Charlotte Thermography Center

10550 Independence Pointe Parkway Ste. 100
Matthews, NC 28105
704-849-9393

**Patient Pre-Scan Instructions:**

To achieve an accurate evaluation, you should avoid conditions that would cause artificial influences. Please fill out your patient history forms prior to your appointment and contact our office with any questions you might have that are not covered here.

1. Unless specifically instructed by your physician, you should wait at least three (3) months after any form of breast surgery (including biopsy), the completion of chemotherapy or radiation before your study.
2. You should avoid any natural or artificial tanning of your chest for three (3) days prior to your study.
3. You must avoid any vigorous physical stimulation, examination or compression of the breasts (self or clinical examination, ultrasound or mammogram) for at least three (3) days prior to your study.
4. You must not have had significant fevers (102 or more) within thirty-six (36) hours of your study or have any level of fever on the day of your study.
5. You should refrain from a sauna, steam-room or hot/cold packs in contact with your breasts for at least twenty-four (24) hours prior to your study.
6. There should be no new bruising, rashes or skin irritation on your breasts or underarms on the day of your study.
7. You should not use any skin creams, lotions, deodorants or powders that may cause inflammation on your breasts or underarms on the day of your study.
8. With your physician's permission, please do not use the following medications for twelve (12) hours prior to your study: niacin or niacin patch (500 milligrams or more), nitroglycerin or any migraine medication.
9. You should avoid any tobacco use or caffeinated coffee or tea consumption for two (2) hours prior to your study.
10. You should avoid vigorous exercise, bathing or showering for one (1) hour prior to your study.
11. If you are breast-feeding, please empty your breasts 30-60 minutes prior to your study.
12. Please remove all jewelry.
13. Long hair should be worn up or pulled back off your shoulders prior to being scanned.
14. For your comfort, we recommend you wear a blouse and pants or skirt to your study.
15. For a breast scan, please do not wear a bra to exam but you can bring one for after the exam.

**THE CHARLOTTE THERMOGRAPHY CENTER**

**Notice of Privacy Practices**

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: _____ Date: _____

With whom may we discuss your care:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

How should we contact you?

Phone 1st choice _____

2ND choice _____

e-mail _____

If you prefer to be contacted by phone, may we leave a message -

on the voice mail? Yes No

with the person answering the phone? Yes No

# The Balanced Body Center

## Authorization to use or Disclose Protected health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, The Balanced Body Center may not use or disclose your protected health information except as provided in our Notify 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), and business associates of this office:

**Physicians Insight MD's Clinical Interpretation**

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

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. Receive a copy of this authorization.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Signature of Authorized Representative-Balanced Body Center Date

**THE CHARLOTTE THERMOGRAPHY CENTER**

**Attention: Patients that intend to use your personal health insurance to pay for any portion of care in this office.**

We are not contracted with any insurance companies for thermography services. We ask that you pay at time of service, and we will provide a receipt that you may submit to your insurance company.

I understand that I am responsible for the cost of my thermography.

_____ _____

Signature Date