

Thermal Imaging of Arizona – Breast Health History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

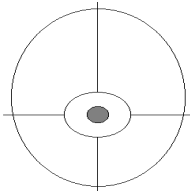
Date of Birth: _____ Age: _____ Sex: _____

Referred by: _____

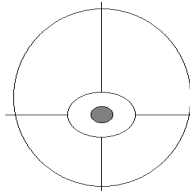
How did you hear about us? AZ Networking News Internet Person Other _____

Reason for imaging today: _____

Place an "x" on the diagram in the area of your concern:



Right Breast



Left Breast

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Date of last physical breast exam by doctor _____

Results: _____

Date of last mammogram _____

Results: _____

Dates of Ultrasound, MRI, biopsy or other tests on Breasts _____

Results: _____

Please check all that apply:

- Previous breast cancer diagnosis? Where and what type _____
- Breast surgery? When and what was done? _____
- Radiation treatment? Date last performed? _____
- Family history of breast cancer? Who? _____
- Fibrocystic or cystic breasts? Other breast conditions? _____

- Have children? How many _____ Age at first pregnancy? _____
- Breast feeding? How many children over 1 month? _____ Currently? Y N
- Pregnant? If not, current cycle day _____
- Menopause? What age did it begin? _____
- Birth control pills use? How many years? _____ Currently taking? Y N
- Prescription hormone replacement? How many years? _____ Currently using? Y N

- Progesterone cream or herbs to balance hormones? What types? _____
 _____ Currently using? Y N
- Other medications? Please list: _____

- Had both ovaries removed? At what age? _____

Doctor to receive copy of report, if any: Name _____
 Address _____
(\$5.00 ea to send to additional doctors) _____ Zip _____
 Phone: _____

May we send him or her your report? Y N

Release for Testing Procedure

Thermal Imaging provides information regarding current and future risk for breast disease and does not replace mammography or any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging examinations.

I have complied with the pre-examination instructions for proper thermal imaging

Print Name _____ **Signature** _____ **Date** _____

Please do not write in this section

Initial Exam Re-Exam Tech _____

Patient T = _____ F Laboratory Temperature _____ F Additional info: _____

Office Use Only
