Patient Preparation Sheet

Health Screening with Digital Infrared Thermal Imaging (Thermography)

Purpose of Test

Early detection of abnormal changes in the body requiring further diagnostic testing

Patient Prep - Day of Test

DO NOT:

- use a tanning booth and avoid overexposure to the sun
- have strenuous exercise
- use heating pads or cold packs
- shave or us lotions, powders, anti-perspirants or makeup
- smoke 2 hours prior
- have physical therapy or electromyography

Do not have acupuncture treatments within 3 days prior to appointment. Wait 3 months post surgery, and 6 months post radiation therapy to schedule an appointment.

Wear loose fitting clothing and remove all jewelry.

Wear hair pinned or clipped up as to see hair line.

No changes necessary for diet or medication.

General Information

Procedure is non-invasive, no-contact, no radiation and FDA Approved.

Thermography is performed by a female certified clinical thermographer and is completely private

Disrobing- Remove all clothing and jewelry. Put on a supplied gown or sarong. Inform your thermographer if you had any recent skin lesions, inflammation may cause a false positive result.

There are no risks and no side effects

We gladly except personal check, cash and credit card for payment

Patient Intake Form

Name _____

DOB _____ Age _____

Address _____

City _____

State _____

Zip _____

Occupation _____

Email _____

For office use only:

Patient ID # _____ Report # _____

IB BB AB WW HB FB

Referred by _____

Location _____ Next F/U Month _____

Scans / Data uploaded _____

Payment _____ V M D AMX FSA

Phone (C) _____ (H) _____

Referring Physician _____ Primary Physician _____

Reason for today's visit:

_____

Current Symptoms: _____

_____

Current Treatment: _____

_____

Previous Illnesses: _____

_____

Previous Surgeries / Dates: _____

_____

Injuries / Dates: _____

_____

Current Medication(s): _____

_____

This information is confidential. All information is correct to my knowledge.

Signature: _____ Date: _____

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Breast Questionnaire

Name:_____ Birthdate:_____

1. Do you have any close relative who has had breast cancer?	Yes	No
2. Have you ever been diagnosed with breast cancer?	Yes	No
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	Yes	No
4. Have you had any biopsies or surgeries to your breasts?	Yes	No
5. Have you had any breast cosmetic surgery or implants?	Yes	No
6. Have you had a mammogram in the past 12 months?	Yes	No
7. Have you had a mammogram in the past 5 years?	Yes	No
8. Have you had abnormal results from any breast testing?	Yes	No
9. Have you ever taken a contraceptive pill for more than 1 year?	Yes	No
10. Have you suffered with cancer of the womb?	Yes	No
11. Have you had pharmaceutical hormone replacement therapy?	Yes	No
12. Do you have an annual physical examination by the doctor?	Yes	No
13. Do you perform a monthly breast self exam?	Yes	No

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__ No __ Never __ Not in last 12 months __ Not in last 5 years__

Have you recently had any of these breast symptoms:	**Right Breast**	**Left Breast**
Pain	❑	❑
Tenderness	❑	❑
Lumps	❑	❑
Change in breast size	❑	❑
Areas of skin thickening or dimpling	❑	❑
Secretions of the nipple	❑	❑

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.

Signature _____ Today's Date _____

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Extended Breast Questionnaire

Patient Name: _____ Date: _____

Diagnosed with breast cancer:

Cancer type: Metastatic___ Local___ Lymph node involvement___

When diagnosed: Month_____ Year_____

Where (left breast): UO____ UI____ LO____ LI____ Nipple____

Where (right breast): UO____ UI____ LO____ LI____ Nipple____

Treatment: Surgery____ Chemo____ Radiation____ Other____ None____

Diagnosed with other breast disease:

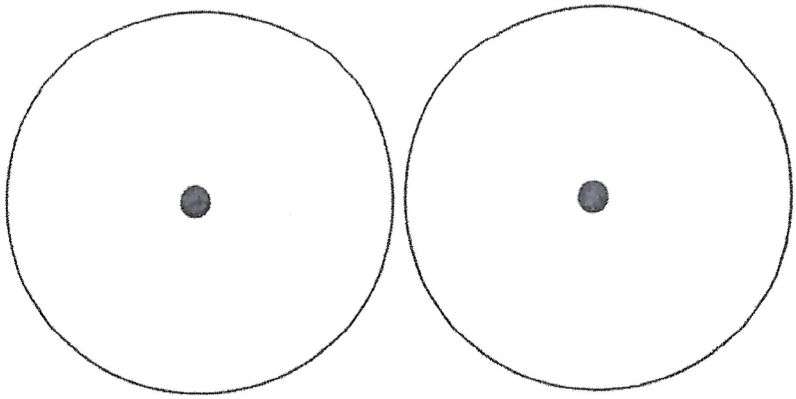
Disease type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other ____

(please report other types of disease in the history)

Breast biopsies or surgery:

Where (left breast): UO____ UI____ LO____ LI____ Nipple____

Where (right breast): UO____ UI____ LO____ LI____ Nipple____



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Patient Review of Body Systems

Name **Date**

Constitutional
___Fevers/Chills/Sweats
___Unexplained weight loss/gain
___Fatigue/weakness
___Excessive thirst or urination

Musculo-SKeletal
___Muscle/Joint Pain

Ears/Nose/Throat
___Difficulty hearing/ringing
___Hay Fever/Allergies

Cardiovascular
___Chest Pain/Discomfort
___Leg Pain w/Exercise
___Palpitations

Other (please specify)
_____
_____

Dental
___Extractions
___Crowns
___Root Canal
___Gum Disease
___Fillings
___Other

Respiratory
___Cough/Wheeze
___Difficulty Breathing

Gastrointestinal
___Heartburn/Reflux
___Nausea/Vomiting/Diarrhea
___Large bowel dysfunction
___Abdominal Pain

Skin
___Rash or Mole

Neurological
___Numbness
___Headaches

Organ Dysfunction
_____
_____

Blood/Lymphatic
___Unexplained Lumps
___Easy Bruising

General Medical History: Past and Current medical problems (please include dates)

___Heart Disease: (specify)
___Diabetes
___Asthma/Lung Disease
___Accidents
___Other: (specify)

___High Blood Pressure
___Thyroid Problem
___Chemical Exposure
___Injuries

___High Cholesterol
___Kidney Disease
___Cancer: (specify)
_____
_____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___High Cholesterol
___Heart Disease
___Bleeding or Clotting
___Asthma/COPD
___Cancer: type _____

___High Blood Pressure
___Stroke
___Genetic Disorders
___Other

___Diabetes

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Authorization to Use or Disclose Protected Health Information

Living Well Thermography

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, *Living Well Thermography* may not use or disclose your protected health information except as provided in our Notice 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), or business associates of this office:

EMI, Electronic Medical Interpretations

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

For the specific purpose of (describe in detail): **Interpretation of said images**

Effective dates for this authorization: ____/____/____ through ____/____/____

This authorization will expire at the end of the above period.

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. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature or Patient or Patient's Authorized Representative **Date**

_____ _____

Authorized Signature of Facility **Date**

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