

FREETHERMALIMAGE.COM

**Call For
Appointment Today**

Name : _____ Birth Date: _____
Last First MI Month / Day / Year

Occupation: _____ Duration in this occupation: _____

Mailing Address: _____
Street City State Zip Country

E-Mail: _____

Home Ph#: (____) _____ Cell Phone#: (____) _____ Work Phone#: (____) _____

Emergency Contact: _____ Home Ph#: (____) _____ Cell Phone#: (____) _____
Last First

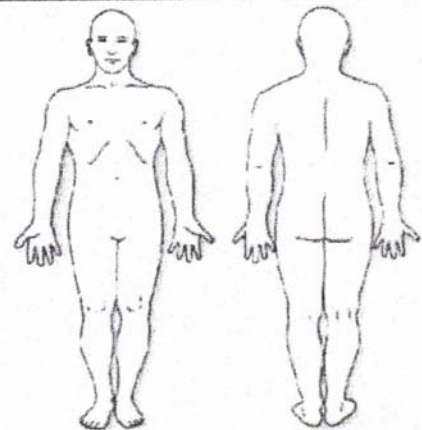
For An Appointment to Review Your Report with our Certified Reading Doctor, There is a \$25 Fee.

You Will Receive Your Report Via Email (If Email Is Not Available, You Will Receive It Via Postal Mail)

Patient Thermographic & Breast Examination Questionnaire

All information provided will remain strictly confidential.

*Are you Right or Left Handed?	Left	Right	Y	N	
1. Do you have any close relative that has had breast cancer?					If yes, Relationship:
2. Have you ever been diagnosed with breast cancer?					If yes, Type: Metastatic / Lymph node involvement / Local
3. Have you ever been diagnosed with any other breast disease?					If yes, When: Month - Year -
4. Have you had any biopsies or surgeries to your breasts?					If yes, at what location: Right: Left:
5. Have you had breast cosmetic surgery or implants?					If yes, When: Month - Year -
6. Have you had a mammogram in the last 12 months?					Mark your area(s) of Pain (Circle your present pain level) None - 1 2 3 4 5 6 7 8 9 10 - Severe
7. Have you had a mammogram in the last 5 years?					
8. How many mammograms had you had in total?					Total:
9. At What age did you have your first mammogram?					Age:
11. Have you had any abnormal results from any breast testing?					If yes, What:
12. Have you ever taken a contraceptive pill for more than 1 year?					
13. Have you suffered with cancer of the womb?					
13. Have you had pharmaceutical hormone replacement therapy?					
14. Do you have an annual physical examination by a Doctor?					
15. Do you perform a monthly breast self exam?					
16. How many births have you had?					Total:
17. What was your age when your first child was born?					Your Age:
18. Did your menstrual periods start before the age of 12?					
19. Did your menstrual periods stop after the age of 50?					
20. Do you smoke?					How many packs per day?
21. Have you (last 6 months) had any of these breast symptoms:					
Pain					
Tenderness					
Lump(s)					
Change in breast size					
Area of skin thickening or dimpling					
Secretions of the nipple					
22. Previous Illness?					If yes, What:
23. Previous Surgery?					If yes, What:
24. Current Health Problems?					If yes, What:
25. Currently taken any medication?					If yes, What:
Patient Disclosure I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis, or treatment. I understand the report will not tell me whether I have an illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Integrative Thermal Imaging and Dr. Gregory Melvin, D.C. I further authorize direct payment of services to Integrative Thermal Imaging and Dr. Gregory Melvin, D.C.					
Patient Signature: _____					Date: _____



Comments: _____