

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

Today's date: \_\_\_\_\_

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

Pain indicated by a line/ X if numbness indicate N, Scale 1 2 3 4 5 6 7 8 9 10 level of pain 10 is severe pain  
Note : Scars from injuries / surgeries indicate an S and line of scar pattern, moles an M and fractures an F

Arm dominance : left handed      right handed

Which do you suffer from, indicate by circling :

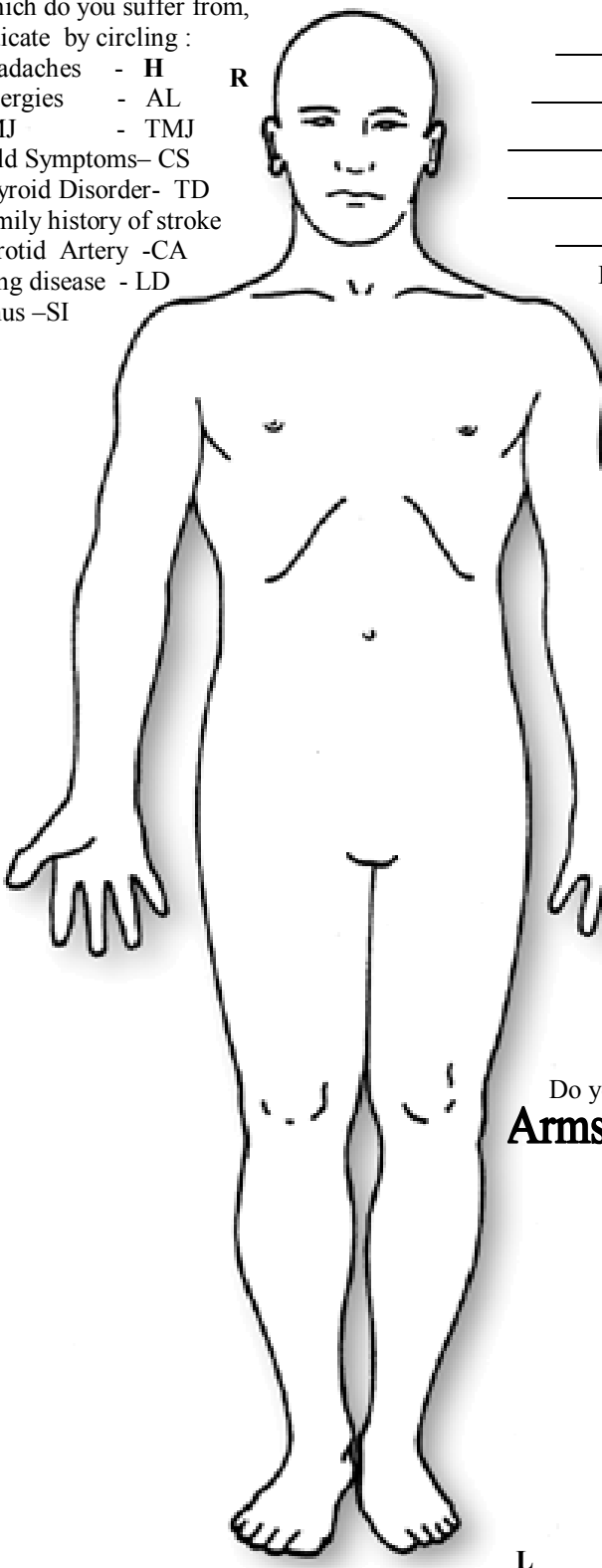
- Headaches - **H**      **R**
- Allergies - AL
- TMJ - TMJ
- Cold Symptoms- CS
- Thyroid Disorder- TD
- Family history of stroke
- Carotid Artery -CA
- Lung disease - LD
- Sinus -SI

\_\_\_\_\_

\_\_\_\_\_

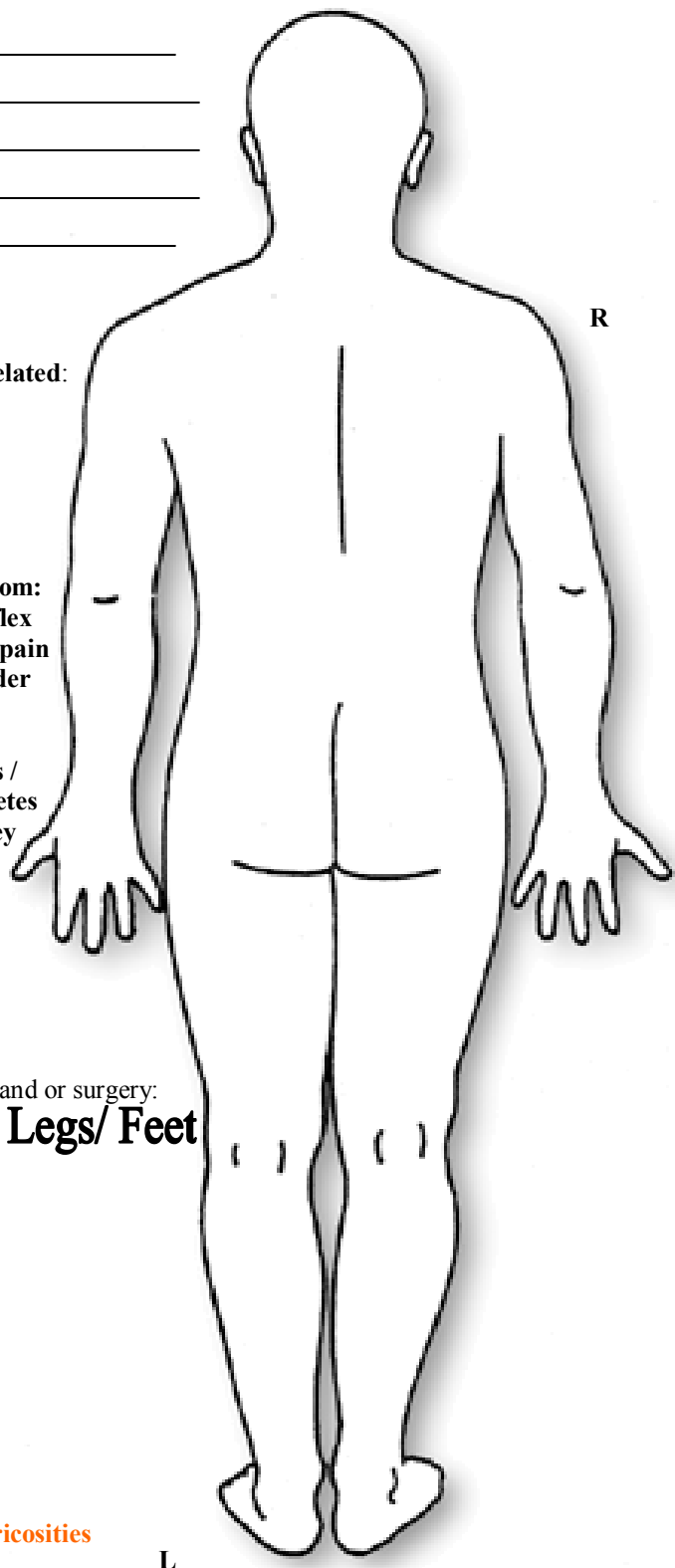
\_\_\_\_\_

\_\_\_\_\_



L

- Surgeries related:**
- Lung
  - Heart
  - Spine
- Suffer from:**
- Acid Reflex
  - Stomach pain
  - Gallbladder
  - Liver
  - Spleen
  - Pancreas /
  - Diabetes
  - Kidney



R

Do you suffer pain and or surgery:  
**Arms/ Hands/ Legs/ Feet**

Indicate Varicosities

Surgeries related : \_\_\_\_\_

When was your last thermal: / /

I was referred by \_\_\_\_\_

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

Birth Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Home Ph. # \_\_\_\_\_ Cell Ph.# \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Home Ph.# \_\_\_\_\_

Format you desire to receive your report : In person by appointment / Mail / E-Mail

## Breast Questionnaire

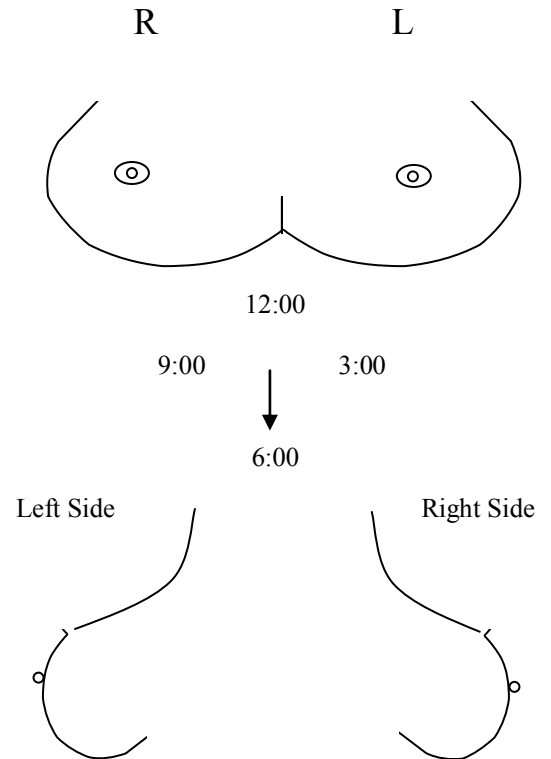
(Circle Yes/ No with Clock positions on positive findings)

Room Temperature: start  C  F  
 end  C  F

1. Do you have any close relative that has 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? Yes No
4. Have you had any biopsies to the breasts and your findings? Yes No
5. Have you had breast cosmetic surgery or implants? → Yes No
6. Have you had a mammogram in the last 12 months? → Yes No
7. Have you had a mammogram in the last 5 years? → Yes No
8. How many mammograms had you had in total? Total # \_\_\_\_\_
9. At what age did you have your first mammogram? Age # \_\_\_\_\_
10. Have you ever taken a contraceptive pill for more then 1 year? → Yes No
11. Have you suffered cancer from the womb? → Yes No
12. Have you had pharmaceutical hormone replacement therapy? → Yes No
13. Do you have an annual physical examination by a Doctor? → Yes No
14. Do you perform a monthly breast self examination? → Yes No
15. How many births have you had? Total# \_\_\_\_\_
16. What was your age when your first child was born? Your Age# \_\_\_\_\_
17. Did your menstrual periods start before the age of 12? → Yes No
18. Did your menstrual periods stop after the age of 50? → Yes No
19. Do you smoke? Yes No How long? \_\_\_ Number packs per day? \_\_\_\_\_
20. Have you had any of these breast symptoms in the last 6 months? \_\_\_\_\_

If yes, Relationship: \_\_\_\_\_  
 If yes, type Metastatic/ Lymph node/ Local  
 When: \_\_\_\_\_  
 Where: Right : : Left : :  
 If yes, findings: fibrocystic / calcium nodule  
 When: \_\_\_\_\_  
 Where: Right: : : Left: : :

	Yes	No				
Pain	Y	N	Left	Right	Both	Previous Illness? _____
Tenderness	Y	N	L	R	B	_____
Lump(s)	Y	N	L	R	B	_____
Change in breast size?			L	R	B	_____
Area of skin thickening or dimpling?			L	R	B	Previous surgeries? _____
Secretion of the Nipple?			L	R	B	_____
Current Health Problems?	_____					_____
Current medications?	_____					_____



### Patient Disclosure

*I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, analysis 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 Gregory Melvin, D.C., B.C.C.T. I further authorize direct payment of services to Dr. Gregory Melvin.*

Patient Signature : \_\_\_\_\_

Date : \_\_\_\_\_