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**Breast Thermography Confidential Questionnaire**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No**

**1. Do you have any close relative who has had breast cancer? ⁬**

**2. Have you ever been diagnosed with breast cancer? ⁬ ⁬**

**3. Have you ever been diagnosed with any other breast disease (fibrocystic)? ⁬ ⁬**

**4. Have you had any biopsies or surgeries to your breasts? ⁬ ⁬**

**5. Have you had any breast cosmetic surgery or implants? ⁬ ⁬**

**6. Have you had a mammogram in the past 12 months? ⁬ ⁬**

**7. Have you had a mammogram in the past 5 years? ⁬ ⁬**

**8. Have you had abnormal results from any breast testing? ⁬ ⁬**

**9. Have you ever taken a contraceptive pill for more than a year? ⁬ ⁬**

**10. Have you suffered with cancer of the womb? ⁬ ⁬**

**11. Have you had pharmaceutical hormone replacement therapy? ⁬ ⁬**

**12. Do you have an annual physical examination by a doctor? ⁬ ⁬**

**13. Do you perform a monthly breast self exam? ⁬ ⁬**

**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: ⁬ 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 ⁬ ⁬**

**All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting Thermologist and any other practitioner that you specify.**

**PATIENT DISCLOSURE: PLEASE READ CAREFULLY**

I understand that the Report generated from my images is intended for the 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Could you please let us know how you found out/heard about Thermalogica:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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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):** OU\_\_\_\_ UI\_\_\_\_ LO\_\_\_\_ LI\_\_\_\_ Nipple\_\_\_\_

**Where (Right Breast):** OU\_\_\_\_ UI\_\_\_\_ LO\_\_\_\_ LI\_\_\_\_ Nipple\_\_\_\_

**Any further information or notes for client file – please write below:**