PATIENT PRE-EXAM INSTRUCTIONS

PATIENT INSTRUCTIONS:

***Remove ALL jewelry, including permanent jewelry and piercings, BEFORE you arrive.**
***No physical therapy, massage, or chiropractic adjustments, acupuncture or electromyography 24 hours prior to scan.**
***No vigorous exercise or intimate relations 24 hours prior to scan.**
***NO SMOKING for a minimum of 2 hours prior to thermography.**
***NO POWDERS, LOTIONS, DEODORANT OR PERFUMES before scan.**
***NO MAKEUP ON FACE for full body imaging**
***Avoid strong sunlight the day of scan.**
***No sunburn that is active or peeling. If so, delay scan until completely gone.**
***There are no dietary restrictions; with the exception of; food or drink that is excessively hot or cold 2 hours prior to scan.**
***Please wear loose fitting clothing, if possible.**
***NO SHAVING under arms, legs or anywhere else for 24 hours prior to any full body scan.**
***NO SHAVING under arms for 24 hours prior to breast imaging.**
***Please put hair up and off ears and neck, if hair is longer.**

FREQUENTLY ASKED QUESTIONS

1. Where is the test performed?
-X-ray laboratory, hospital, doctor's office, clinician's office.
2. Who performs the test?
-Clinical thermographer, X-ray technician, doctor
3. Are there any risks or side effects?
-None. Thermography is a non-invasive procedure.
4. Do I have to disrobe?
-Yes, but you are provided with a gown until the scan begins. Then you will be asked to remove it.

****IMPORTANT: If you are pregnant or breastfeeding, had surgery in the area of interest, or any biopsies, chemo, or radiation, you will need to wait 3 months after any of these events have stopped.**
****Please keep these instructions for reference when you return for follow ups and yearly scans.**

Patient Information Sheet

Name:_____D.O.B:_____/_____/_____
Address:_____
Phone Number:_____
Email:_____
Occupation:_____

****

Number of children (and birth years):_____
_____

Current illnesses:_____
_____

Current diagnosis (and years):_____
_____
_____

Previous surgeries (and years):_____
_____
_____

Any current health issues:_____
_____
_____

Medications:_____
_____
_____

Other treatments:_____
_____
_____

Any vaccines in the past 4 weeks: YES_____NO_____
Type:_____
Area given:_____

****THIS INFORMATION IS CONFIDENTIAL****

Signed:_____Date:_____/_____/_____

Full Body Study Questionnaire

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

Name: **Birthdate**

Address: _____

City **Zip**

Phone: _____ **Your Doctor:**

Please Show areas of :

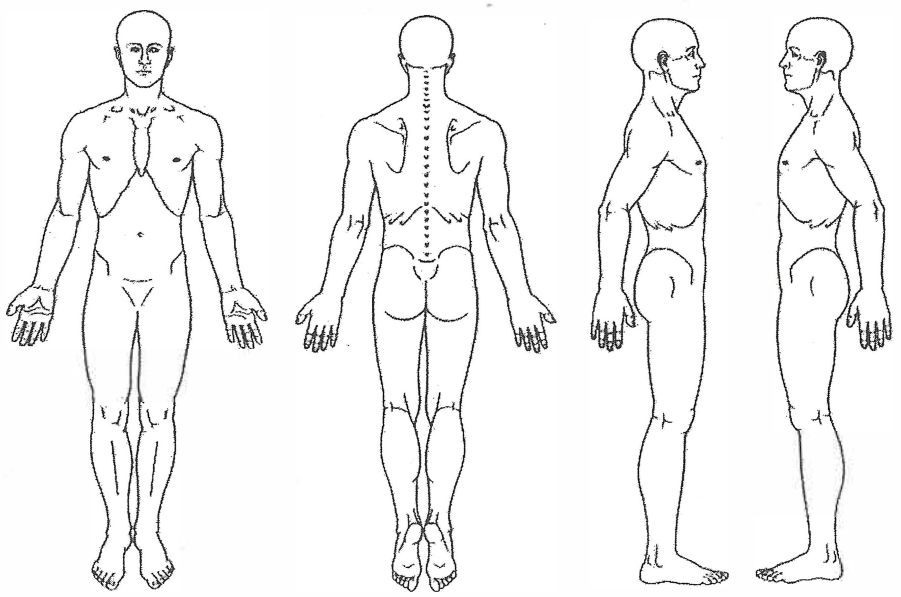
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring



Do you know what triggered the pain ?

Does anything relieve it ?

Does anything aggravate it ?

Has it changed since it began ?

Have you had any treatment ?

History: Injuries / Fractures / Surgery

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 of the areas discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature .....

Name: _____ **Birthdate:** _____

Address: _____ **City** _____ **Zip** _____

Email: _____ **Phone:** _____ **Doctor:** _____

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.

Breast Thermography Confidential Questionnaire

	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 bad any biopsies or surgeries to your breasts?	☐	☐
5. Have you bad 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 1 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	☐	☐

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 _____

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____

Authorization to Use or Disclose Protected Health Information

Medical Thermographic Imaging

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *Medical Thermographic Imaging* 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 that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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*