501 Islington Street, Suite 2B, Portsmouth, NH 03801
Phone (603) 610-8882 Fax (603) 463-0943

Thermography Intake Sheet

Name ____ D.O.B. ___________________ Age ___________

Address ____

Phone (H) ____ (W) ___________________________________

Email ____

Occupation ____

Previous Illnesses:

Previous Surgery:

Current Health Problems:

Medication ____

Other Treatment ____

Current Doctor ____

Do you want a copy of the thermogram report forwarded to your doctor? Yes_____ No_____

If yes, what is their address? ____

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

Signed ____ Date _________________________

Breast Thermography Questionnaire

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.

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? ◯ 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 a 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 ◯ Never ◯ Not in the last 12 months ◯ Not in the 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 ____ 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:

(Please report other types of disease in history)

Disease type:	◯ Fibrocystic	◯ Cystic	◯ Mastitis	◯ Abscess	◯ Other

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

Meditherm

Patient Name: ____

Address: ____

Date of Birth: ____ Date of Request: ________________________

As required by the Privacy Regulations, *Meditherm* 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 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: ____________________

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 the 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 of Patient or Patient's Authorized Representative *Date*

____ ______________________________

Authorize Signature of Facility *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: ____

Phone: ________________________________ Your Doctor: _____________________________

Please use specified indicators to show areas of:

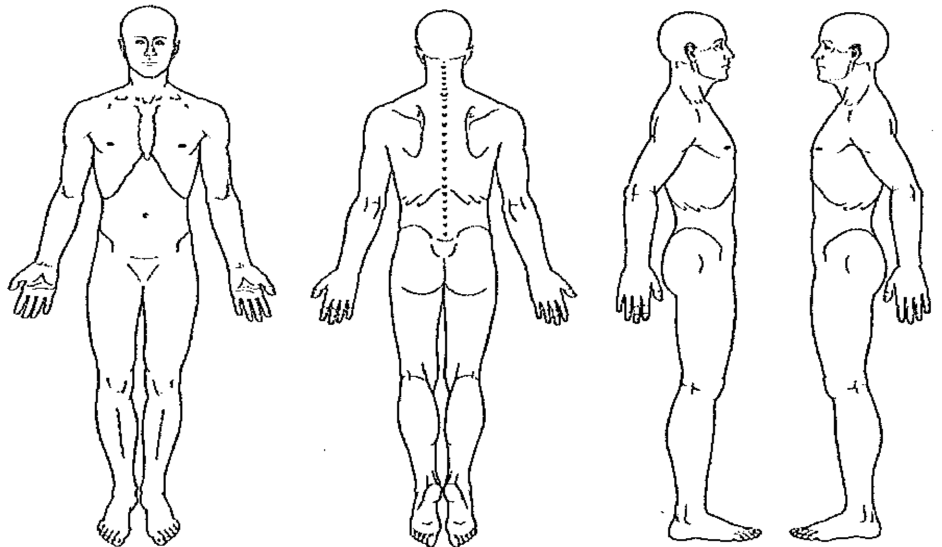
☆ Pain

○ 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?

History of Injuries, Fractures or Surgery:

Have you had any treatment?

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 illnesses, 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 ____ Date: ________________________________