River Of Life Wellness

Breast Thermography Questionnaire

All information provided in this questionnaire will remain strictly confidential and only shared with the reporting thermologist and any other practitioner that you specify.

Name: _____ **DOB:** _____ **Patient ID#:** _____

Do you have a relative who has had breast cancer? Y ☐ N ☐

If you answered yes, please explain: _____

Have you ever been diagnosed with breast cancer? Y ☐ N ☐

Have you ever been diagnosed with any other breast condition? Y ☐ N ☐

If you answered yes, please explain: _____

Have you had any biopsies or surgeries to your breasts? Y ☐ N ☐

If you answered yes, please explain: _____

Have you had cosmetic breast surgery or implants? Y ☐ N ☐

If you answered yes, please explain: _____

Have you had a mammogram in the past 12 months? Y ☐ N ☐

Have you had a mammogram in the past five years? Y ☐ N ☐

Have you had abnormal results from any breast testing? Y ☐ N ☐

Have you ever taken a contraceptive pill for more than one year? Y ☐ N ☐

Have you ever had cancer of the cervix, uterus, or ovaries? Y ☐ N ☐

Have you had pharmaceutical hormone replacement therapy? Y ☐ N ☐

Do you have an annual physical exam by a doctor? Y ☐ N ☐

How many mammograms have you had total (estimate ok): _____

Date of last mammogram (MM/YY): : _____ **Were the results normal?** Y ☐ N ☐

What was your age when you had your first mammogram? _____

How many births have you had? _____ **Your age at birth of first child?** _____

Did your periods start before the age of 12? Y ☐ N ☐

Did your periods stop after the age of 50? Y ☐ N ☐

Do you smoke? Y ☐ Never ☐ Not in last 12 months ☐ Not in last 5 years ☐

Have you recently had any of these breast symptoms?	**R Breast**	**L 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 healthcare providers to assist in evaluation, diagnose, 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 an illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings discussed in the report. In order to obtain an accurate baseline pattern, River of Life Wellness requires a three-month, follow-up thermography. The purpose of the three month comparison is to establish the baseline pattern for which all future thermograms are compared to monitor stability. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature: _____ **Today's Date:** _____