Midwest Medical Thermography
and Health Services

RETURNING PATIENT INFORMATION SHEET
(This information is confidential)

NAME: _____DOB _____AGE: _____

MAILING ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

PHONE:_____EMAIL:_____

OCCUPATION:_____ REFERRING MD:_____

Has anything changed since your last visit? Surgery? Injury? Medication?

When was your most recent mammogram?
Mammogram findings?
When was your most recent breast palpation?
Breast pain or tenderness?
Have you noticed any lumps, secretions or nipple retraction?
(If full body, circle any areas of concern on full-body form)

All information is correct to the best of my knowledge.

Signed: _____ Date: _____

For office use only

Scan Type: _____ PT ID: _____ Rpt. #: _____ Location: _____

Referred by: _____ EMI: ___ E-mailed: ___ Call: ___ Mailed: ___ ROF: ___ WIX: ___

Payment: $_____ _ Cash/CC/Check # _____ Rcpt: Y / N mail/email DH: $_____

Midwest Medical Thermography
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Full Body 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.

Name: _____ D.O.B: _____

Please Show areas of :

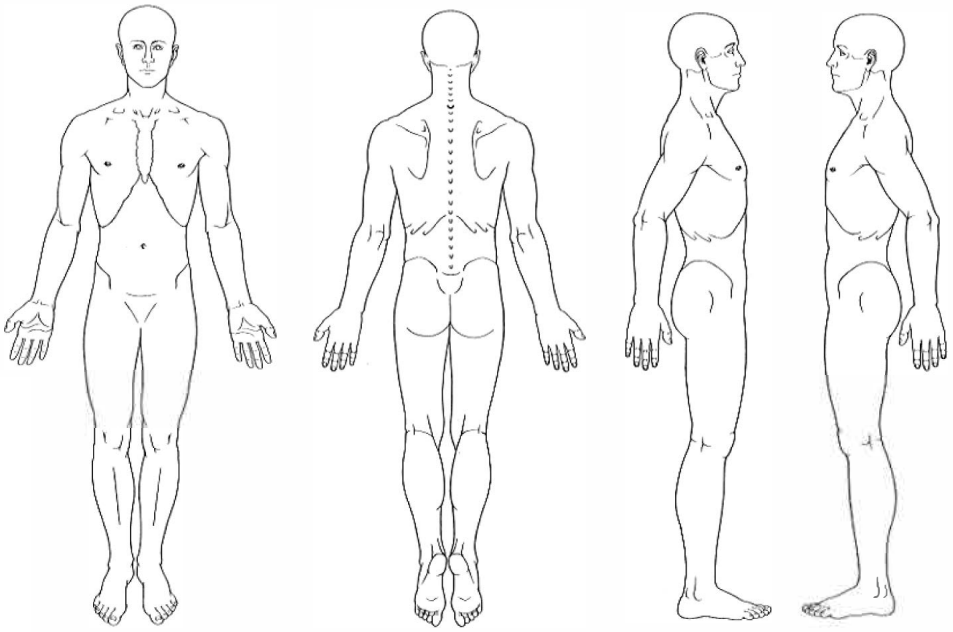
Main Pain ✻

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 _____ Date _____

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Breast Thermography Confidential Questionnaire

Name _____ **Date of Birth** _____

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.

Please mark YES or NO as it applies to you:	**YES**	**NO**
Do you have any close relative who has had breast cancer?		
Have you ever been diagnosed with breast cancer?		
Have you ever been diagnosed with any other breast disease? (Fibrocystic?)		
Have you had any biopsies or surgeries to your breasts?		
Have you had any breast cosmetic surgery or implants?		
Have you had a mammogram in the past 12 months?		
Have you had a mammogram in the past 5 years?		
Have you had abnormal results from any breast testing?		
Have you ever taken a contraceptive pill for more than a year?		
Have you suffered with cancer of the womb?		
Have you had pharmaceutical hormone replacement therapy?		
Do you have an annual physical *breast* examination by a doctor?		
Do you perform a monthly breast self exam?		
Did your period start before the age of 12?		
Did your periods end after the age of 50?		
Have you had a vaccination in the last 4 weeks? (Indicate arm: L___ R___ No___)		

How many mammograms have you had in total? _____
What was your age when you had your first mammogram? _____
How many children have you given birth to? ___ Age at the birth of your first child: ___
Do you smoke? Yes ___ Never ___ Not in last 12 months ___ Not in last 5 years ___

Breast Thermography Confidential Questionnaire

Have you **recently** had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	Right Breast	Left Breast
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Patient Disclosure

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

Signature_____ Date_____