Midwest Medical Thermography

PATIENT INFORMATION SHEET

(This information is confidential)

NAME: _____ DOB: _____AGE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE: _____ CELL: _____

EMAIL: _____

OCCUPATION: _____

Health Concerns:

Illnesses:

Surgeries:

Family History (parents/siblings):

Medication: _____

Other Treatment: _____

Physician: _____

All information is correct to my knowledge.

Signed: _____ Date: _____

For office use only

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

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

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

Midwest Medical Thermography
and Health Services

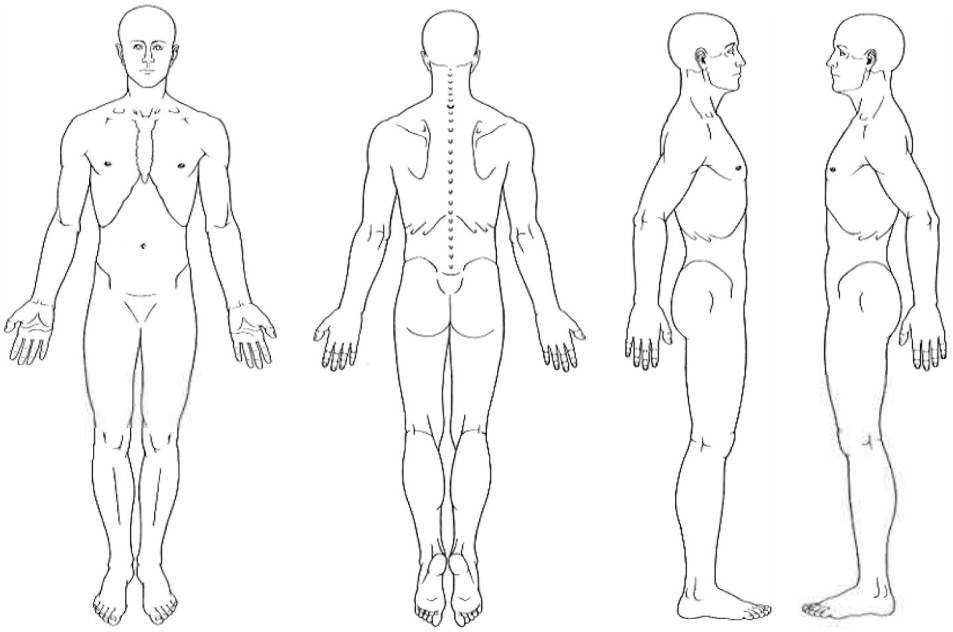
Full Body Questionnaire

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 _____

Breast Thermography Confidential Questionnaire

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.

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 examination by a doctor?		
Do you perform a monthly breast self exam?		

How many mammograms have you had in total? _____
What was your age when you had your first mammogram?_____
How many births have you had?_____ Your age at the birth of your first child:_____
Did your period start before the age of 12?_____ Or finish after the age of 50?_____
Do you smoke? Yes____ Never____ Not in the last 12 months____ Not in the last 5 years____
Had a vaccination in last 4 weeks? Indicate which arm: Left ___ Right ___ No ____

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		

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Signature _____ Date _____

WOMEN'S HEALTH CONFIDENTIAL QUESTIONNAIRE

NAME:_____ DATE OF BIRTH:_____

Is your menstrual cycle regular? ❍ Yes ❍ No

Do you have heavy bleeding with your menstrual cycle? ❍ Yes ❍ No

Do you have lumps in your breasts that come and go? ❍ Yes ❍ No

Do you experience pre-menstrual headaches? ❍ Yes ❍ No

Do you have low libido? ❍ Yes ❍ No

Do you have hot flashes? ❍ Yes ❍ No

Do you experience mood swings? ❍ Yes ❍ No

Have you ever been diagnosed with endometriosis? ❍ Yes ❍ No

Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)? ❍ Yes ❍ No

Have you ever been treated for infertility? ❍ Yes ❍ No

Have you had difficulty conceiving? ❍ Yes ❍ No

Do you have any swelling in the neck or trouble swallowing? ❍ Yes ❍ No

Have you been diagnosed with any thyroid disorder? ❍ Yes ❍ No

If yes, what type: ❍ Hypothyroid ❍ Hyperthyroid ❍ Hashimoto's ❍ Grave's Disease

Are you on a thyroid medication or supplement? ❍ Yes ❍ No What kind?_____

Do you regularly experience fatigue? ❍ Yes ❍ No

Have you experienced recent hair loss? ❍ Yes ❍ No

Have you experienced unexplained weight gain? ❍ Yes ❍ No

Have you experienced unexplained weight loss? ❍ Yes ❍ No

Are you intolerant to cooler temperatures/ sensitive to cold? ❍ Yes ❍ No

Do you experience chronic insomnia? ❍ Yes ❍ No

Do you experience chronic brain fog? ❍ Yes ❍ No

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_____ _____

Signature of Patient or Patient's Authorized Representative Today's Date