

***New England Clinical Thermography***  
**Breast Thermography Confidential 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: \_\_\_\_\_ MI: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: \_\_\_\_\_ Doctor: \_\_\_\_\_

- |   | Yes | No  |
|---|-----|-----|
| 1. Do you have any close relative who has had breast cancer?<br>If yes, which relative? _____ | ___ | ___ |
| 2. Have you ever been diagnosed with breast cancer?   | ___ | ___ |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)?                  | ___ | ___ |
| 4. Have you had any biopsies or surgeries to your breasts?                                    | ___ | ___ |
| <b><u>If you answer yes to any of questions 2, 3 or 4 you must complete page 2!!!</u></b>     |     |     |
| 5. Have you had 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? (Circle) Yes Never Not in last 12 months Not in last 5 years                |     |     |
| Have you <u>recently</u> 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  | ___ | ___ |
| <b><u>If you have any of the above symptoms, see page 2</u></b>                               |     |     |

**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: \_\_\_\_\_ Local \_\_\_\_\_ Lymph node involvement \_\_\_\_\_

When diagnosed: Month \_\_\_\_\_ Year \_\_\_\_\_

Where:	left breast	right breast
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

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: (indicate which)

Where:	left breast	right breast
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

Dates of biopsies/surgery \_\_\_\_\_

Result of biopsies/surgery \_\_\_\_\_

Recent breast symptoms: Are they menstrual cycle related? Yes No (circle)  
If not, how recently did they develop? \_\_\_\_\_

Any other comments on breast symptoms: \_\_\_\_\_