

ID Code _____
(Office Use Only)

STUDY DATE _____
(Office Use Only)

Name _____
Last First Middle

Study Type Routine STAT

Date of Birth _____ AGE _____

For all questions below, if **YES**, please provide details, otherwise indicate **NO** and move on to the next question.

1. Previous thermology? NO YES
Date _____ Site _____

9. Have you gained **more** than **30** pounds **after** you completed menopause? NA NO YES

2. Have you **ever** been diagnosed with **breast cancer**?
 NO YES Date of biopsy _____
Side: RIGHT LEFT
Stage 0 1 2 3 4 Unknown
Type: Ductal Lobular Inflammatory
 Paget's Phyllodes Don't Recall
Surgery None Lumpectomy Mastectomy
Treatment None Radiation Chemotherapy
Date of Last Treatment _____
Reconstruction: None DIEP Lat Dorsi flap
 SGAP TRAM flap Autologous fat graft
 Implant Other _____ Date _____

10. Have **any** of your **blood relatives** been diagnosed with breast **or** ovarian cancer? NO YES
 Mother Daughter(s) Sister(s) Aunt(s)
 Cousin(s) Grandmother(s) Niece(s)
 Other _____ Were they diagnosed at the age of **40 or younger**? NO YES
List Relationship and Age when Diagnosed

3. Have you had non-cancer breast surgery? NO YES Side: RIGHT LEFT
 Aspirations Biopsy Implants Lift
 Reduction Other _____
Date(s) _____

11. Age at **first** mammogram _____ Total # _____
Date of **last** mammogram _____

4. Have you had any **abnormal** results from breast testing? NO YES Side: RIGHT LEFT
 Physical Mammogram Ultrasound MRI
DATE(s) _____

12. Age at **first** menstrual period _____

13. Have you had endometrial ablation? NO YES
Date (or age) _____

5. Have you ever been diagnosed with any type of **non-cancer** breast disease? NO YES
Side: RIGHT LEFT Type: Fibro-Cystic
 Mastitis Other _____ Date _____

14. Date (or age) of your **last** menstrual period _____

15. Have you **ever** used hormone contraceptives?
 NO YES Age started _____ How long _____
15a. Did you use these drugs 4 or more years **before** your first child? NA NO YES

6. Have you **ever** been diagnosed with **ovarian** cancer?
 NO YES Date of diagnosis _____
Stage: 1 2 3 4 Unknown
Date of Last Treatment _____

16. Have you taken contraceptives or **prescribed** hormone replacement therapy (HRT) containing **estrogen** in the past **three (3)** months? NO YES
Medication Name _____

7. Have you had surgery for the removal of **both** ovaries?
 NO YES Date of Surgery _____

17. Have you taken **prescribed estrogen (HRT)** 4 or more years? NO YES

18. Age at **first** pregnancy _____ Age at **first** childbirth _____

19. Are you **now** pregnant? MAYBE NO YES

8. Have you **ever** had radiation **treatments** to your chest or back? NO Yes Date or Age _____

20. Are you currently breastfeeding? NO YES
Breast Favored RIGHT LEFT EQUAL
How Long? _____

21. Did you breast feed any of your children for more than 6 months? NA NO YES

Name _____
Last First Middle

Address _____
Number Street Apt.
City State Zip

Phone _____ E-Mail _____

Primary Physician _____ DO MD

Physician's Address _____
Number Street Suite
City State ZIP Phone

Other Physician _____ DO MD

Physician's Address _____
Number Street Suite
City State ZIP Phone

INFORMED CONSENT and RELEASE

Your signature below will acknowledge that you have been offered, read and understand Thermo-Scan Reference Laboratory, LLC. Privacy practices, Informed Consent, Participation in Scientific and/or Medical Studies and the Authorization and Report Release; that you consent to the thermology procedure and instruct us to release your thermology report to the physician(s) and others you have specified on this form. Your signature also indicates you have complied with the preparation protocols as instructed.

With this release you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information. NO YES

Signature: _____ Date _____

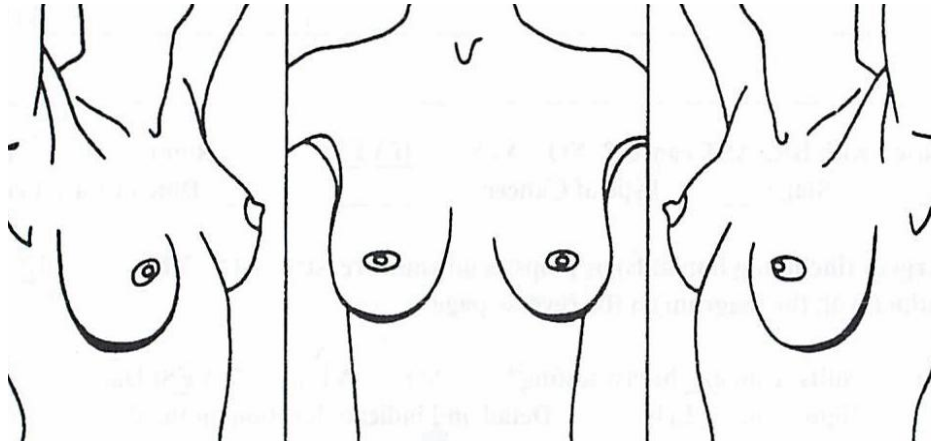
Please indicate the symptoms that you have experienced in the past 6 months and indicate the specific area(s) related to your symptom(s) on this drawing.

Right Breast

- Pain
- Tenderness
- Lumps
- Skin Thickening
- Discoloration
- Changes in Shape
- Changes in Size
- Rash

Right Nipple

- Discharge
- Discoloration



Left Breast

- Pain
- Tenderness
- Lumps
- Skin Thickening
- Discoloration
- Changes in Shape
- Changes in Size
- Rash

Left Nipple

- Discharge
- Discoloration

Technician Notes:

Technician Initials: _____

Thermo-Scan Reference Laboratory Use Only

Study # _____

R _____ L _____