

MEDICAL INFRARED THERMOGRAPHY

Breast Health History

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ E-mail: _____

Marital Status: S M D W SEP Number of Children: _____ Referred By: _____

Y N Do you have a family history of breast cancer?

Self Mother Grandmother Sister Daughter None

Y N Do you have any diagnosed breast conditions?

None Fibrocystic Cystic Other _____

Y N Have you previously had a thermogram? Date of most recent _____

Was it: Normal Abnormal Suspicious Being watched R L Breast

Y N Have you had a mammogram? Date of most recent _____

Was it: Normal Abnormal Suspicious Being watched R L Breast

Y N Have you had an ultrasound? Date of most recent _____

Was it: Normal Abnormal Suspicious Being watched R L Breast

Y N Have you had a breast exam by a doctor? Date of most recent _____

Was it: Normal Lump Found R L Breast

Y N Any breast biopsies?

When and what type (i.e. needle, core)? _____ R L Breast

Y N Any breast surgeries? When and what was done? _____ R L Breast

Y N Have you had a mastectomy? When? _____ R L Breast

Y N Have you had radiation? When was it last performed? _____ R L Breast

Y N Have you had your ovaries removed? At what age? _____

Y N Do you have children? _____ At what age was your first full term pregnancy? _____

Y N Did you nurse for at least three months? How long _____

Y N Are you currently nursing?

Y N Are you currently pregnant?

Y N Are you currently taking birth control pills?

At what age did you start? _____ For how many years? _____

Y N Are you in menopause? At what age did it begin? _____

Y N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?

How many years taken? _____

Y N Are you currently using natural progesterone cream?

Applied to Breasts only Rotating body areas

Y N Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen?

Explain _____

Y N Do you feel that you are overweight? How many pounds overweight? _____

Are you experiencing any of the following with your breasts:

Y N A lump. Date found: _____ by Self Doctor

It is: Hard Soft Mobile Tender

Y N Pain

It is Dull Sharp Burning Stinging Tender Changes with my cycle

Y N Thickening

Y N Skin changes (Color Texture Over the lump)

Y N Nipple discharge R L Breast

It is Bloody Milky Through one duct Through multiple ducts

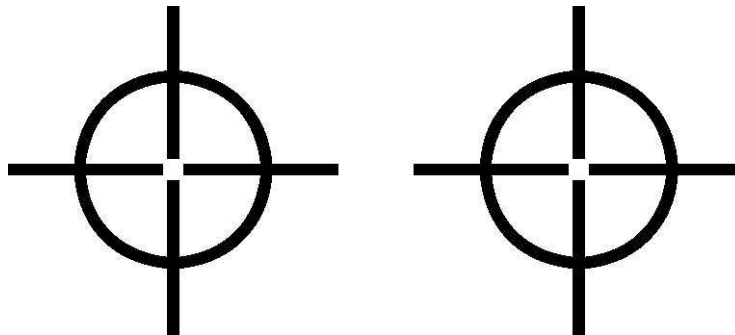
Y N Nipple retraction R L Breast

Y N Nipple changes R L Breast

Change in: Color Texture

Y N Other _____

Place an [O] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [X] in the area of pain, tenderness, thickening, or skin changes.



RIGHT BREAST

LEFT BREAST

Please note any other concerns/issues you may have: _____

General Health Information

Y N Do you have any medical complaints or conditions? Please explain _____

Y N Are you currently taking any medications? Please list _____

Please circle all of the following conditions which you have had:

Abscesses	Depression	Heart Disease	Mononucleosis	Rheumatic Fever	Syphilis
Addiction	Diabetes	Hepatitis	Mumps	Rubella	Tonsillitis
Allergies	Emphysema	Herpes Genitalia	Parasites	Scarlet Fever	Tuberculosis
Amnesia	Epilepsy	Influenza	Pelvic Inflammatory Disease	Sexual Abuse	Typhoid Fever
Arthritis	Gall Stones	Kidney Disease	Disease	Skin Disease	Venereal Warts
Asthma	Goiter	Leukemia	Peritonitis	Strep Throat	Warts
Cancer	Gonorrhea	Malaria	Pleurisy	Sinusitis	Whooping Cough
Chicken Pox	Gout	Measles	Pneumonia	Sunstroke	Worms
Cold Sores	Hay Fever	Miscarriage	Prostatitis	Stroke	Yellow Fever

Other _____

Y N Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Explain? _____

Y N Have you had any operations? Which _____

Y N Have you lost any weight recently? How many pounds? _____

Y N Do you exercise? How often? _____

Y N Have you had any major injuries? Explain _____

Y N Are you taking any of the following substances? How much? Tobacco: _____

Alcohol: _____ Coffee: _____ "Recreational Drugs": _____

Y N Have any of the following ailments affected your relatives:

Alcoholism Asthma Diabetes Gout Mental Illness Skin Disease Allergies Cancer Epilepsy Hay Fever

Paralysis Syphilis Arthritis Depression Gonorrhea Heart Disease Pneumonia Tuberculosis

FAMILY HISTORY Age if Alive / Age at Death AILMENTS

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Children: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____