

# Upper Body Study Questionnaire

All information given will remain confidential and will only be released to the reporting the reporting Thermologist.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Your Doctor: \_\_\_\_\_

### Please show areas of:

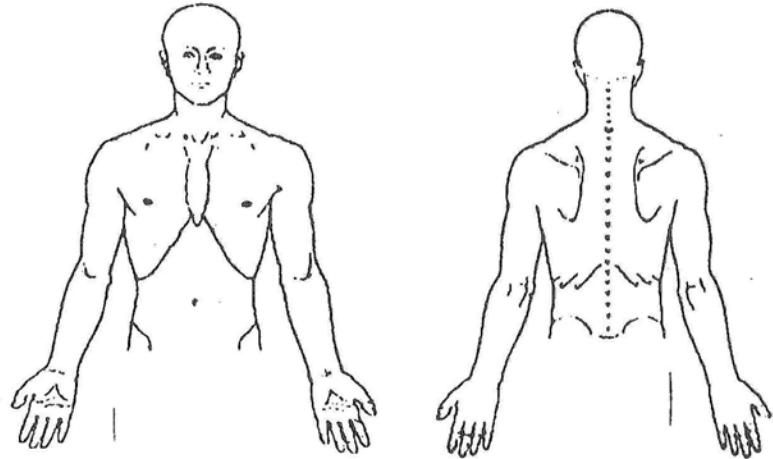
Main Pain \*

Secondary Pain ○

Numbness //

Pins & 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 healthcare providers to assist in evaluation, diagnosis, and treatment. I understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I further 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 area(s) discussed in the Report. By signing below, I certify that I have read and understand the above statements and consent to the examination.

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Doctor: \_\_\_\_\_

**IMPORTANT:** If you answer YES to any of the questions below, please explain on the back of this page .

**Breast Thermography Confidential Questionnaire:** **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 1 year?

Have you suffered with cancer of the uterus?

Have you had 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? \_\_\_\_\_

To how many children have you given birth? \_\_\_\_\_ Your age at birth of your first child: \_\_\_\_\_

Did your periods 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

Have you recently 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

**Patient Disclosure:** I understand that the Report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis, and treatment. I understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I further 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 area(s) discussed in the Report. By signing below, I certify that I have read and understand the above statements and consent to the examination.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*The above information is confidential and will only be released to the reporting the reporting Thermologist.*

# PATIENT REGISTRATION FORM

Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Previous Illnesses: \_\_\_\_\_

\_\_\_\_\_

Previous Surgery: \_\_\_\_\_

\_\_\_\_\_

Current Health Problems: \_\_\_\_\_

\_\_\_\_\_

Medications, including over the counter: \_\_\_\_\_

\_\_\_\_\_

Other Treatments: \_\_\_\_\_

\_\_\_\_\_

Current Doctor: \_\_\_\_\_

If we need to contact you and/or leave a message, which phone number should be used:

Home    Work    Cell    (*please circle one*)

All the above information is correct to my knowledge.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us? \_\_\_\_\_

ALL THE ABOVE INFORMATION IS CONFIDENTIAL



**Meditherm**

921 E. Ocean Blvd. #2  
Stuart, FL 34994

**772-781-5353**

Barbara Thurman, A.P., CCT  
Florida Licensed Nationally Certified  
Acupuncture Physician  
Certified Clinical Thermographer

## Patient Information

### Breast Screening with Digital Infrared Thermal Imaging (Thermography)

#### **Purpose of test:**

For early detection of abnormal changes in the breasts.

#### **Patient preparation:**

**Do not** smoke for 2 hours before the test, do not use lotions or powder on your breasts on the day of test, avoid sun exposure on day of test. Do not wear deodorant/antiperspirant. Do not have massage, physical therapy, or exercise sessions before the test.

**Diet** - Do not have caffeine 2 hours before the test.

**Medicines** - Beta blockers and anti-inflammatory medications may affect the test. Avoid using these the day of the test.

**Disrobing** - Remove all upper body clothing and jewelry. Put on surgical gown supplied.

**Inform** your Thermographer if you have had any recent skin lesions on your breasts; the inflammation can cause a false positive result.

#### **How the test will feel:**

The room air may feel cool on your breasts as you adjust to room temperature before scanning. Examining rooms are frequently quite cool when you disrobe for the examination. The procedure is totally non-invasive, the camera does not emit radiation of any kind.

#### **Time before test results available:**

Time before results are reported to the doctor or patient varies from a few minutes to a few days.

#### **Frequently asked questions:**

*Where is test performed?*

Thermography clinical laboratory at 921 E. Ocean Blvd. #2.

*Who performs test?*

A Certified Clinical Thermographer.

*Any risks or side effects?*

None. Procedure is totally non-invasive.

*How long does it take ?*

Patient time for test: 15 minutes plus 15 minutes to disrobe and cool.

*Cost of test?*

\$185.00, which includes testing, reports, and digital images. (Extra sets of images are available for an additional charge if needed. )

#### **You are welcome to bring a companion or partner to be present at the examination**

Participation in a DITI early detection program can increase your chance of detecting and monitoring breast disease, as with all other tests, it is still not a 100% guarantee of detection.

**Please be on time for your appointment and bring your completed paperwork with you.**