



# Confidential Questionnaire

## Male *Full Body*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_

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

Phone Number (home) \_\_\_\_\_ (cellular) \_\_\_\_\_ (work) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Referring Physician \_\_\_\_\_

*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.*

### **Head & Neck**

- |   | YES                   | NO                    |
|---|-----------------------|-----------------------|
| 1. Do you suffer with headaches?<br>If yes, <input type="radio"/> once a month or less <input type="radio"/> more than once a month | <input type="radio"/> | <input type="radio"/> |
| 2. Do you have allergies?   | <input type="radio"/> | <input type="radio"/> |
| 3. Do you have TMJ or does your jaw click?  | <input type="radio"/> | <input type="radio"/> |
| 4. Do you currently have a cold?  | <input type="radio"/> | <input type="radio"/> |
| 5. Are you being treated for a thyroid disorder?  | <input type="radio"/> | <input type="radio"/> |
| 6. Do you have neck pain?   | <input type="radio"/> | <input type="radio"/> |
| 7. Do you have upper back pain?   | <input type="radio"/> | <input type="radio"/> |
| 8. Do you have a history of carotid artery disease?   | <input type="radio"/> | <input type="radio"/> |
| 9. Do you have a family history of stroke?  | <input type="radio"/> | <input type="radio"/> |
| 10. Do you currently suffer with sinus problems?  | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

## ***Chest, Heart & Lungs***

- |   | YES                   | NO                    |
|---|-----------------------|-----------------------|
| 1. Have you ever been diagnosed with:         |                       |                       |
| Heart disease?                                | <input type="radio"/> | <input type="radio"/> |
| Lung disease?                                 | <input type="radio"/> | <input type="radio"/> |
| Upper spine disorders?                        | <input type="radio"/> | <input type="radio"/> |
| 2. Do you suffer with upper back pain?        | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain?             | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had surgery to:              |                       |                       |
| Heart?  | <input type="radio"/> | <input type="radio"/> |
| Lungs?  | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back?                            | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you currently smoke?                    | <input type="radio"/> | <input type="radio"/> |
| 7. Have you smoked in the last 5 years?       | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

## ***Abdomen & Lower Back***

- |                                    | YES                   | NO                    |  | YES                   | NO                    |
|------------------------------------|-----------------------|-----------------------|--|-----------------------|-----------------------|
| 1. Do you suffer with acid reflux? | <input type="radio"/> | <input type="radio"/> | 3. Have you had surgery or disease in the: |                       |                       |
| 2. Do you have pain in the:        |                       |                       | Stomach?                                   | <input type="radio"/> | <input type="radio"/> |
| Stomach?                           | <input type="radio"/> | <input type="radio"/> | Spleen? Left upper quadrant                | <input type="radio"/> | <input type="radio"/> |
| Below the right breast?            | <input type="radio"/> | <input type="radio"/> | Liver? Right upper quadrant                | <input type="radio"/> | <input type="radio"/> |
| Below the left breast?             | <input type="radio"/> | <input type="radio"/> | Kidneys?                                   | <input type="radio"/> | <input type="radio"/> |
| Abdomen?                           | <input type="radio"/> | <input type="radio"/> | Intestines?                                | <input type="radio"/> | <input type="radio"/> |
| Lower back?                        | <input type="radio"/> | <input type="radio"/> | Abdomen?                                   | <input type="radio"/> | <input type="radio"/> |
|                                    |                       |                       | Lower back?                                | <input type="radio"/> | <input type="radio"/> |

# Legs & Feet

Check only if the answer is YES

- |                                    |                       |                       |                             |                       |                       |
|------------------------------------|-----------------------|-----------------------|-----------------------------|-----------------------|-----------------------|
| 1. Do you suffer with pain in the: | LT                    | RT                    | 2. Have you had surgery to: | LT                    | RT                    |
| Leg?                               | <input type="radio"/> | <input type="radio"/> | Leg?                        | <input type="radio"/> | <input type="radio"/> |
| Sciatica?                          | <input type="radio"/> | <input type="radio"/> | Sciatica?                   | <input type="radio"/> | <input type="radio"/> |
| Buttocks/Hip?                      | <input type="radio"/> | <input type="radio"/> | Buttocks/Hip?               | <input type="radio"/> | <input type="radio"/> |
| Knees?                             | <input type="radio"/> | <input type="radio"/> | Knees?                      | <input type="radio"/> | <input type="radio"/> |
| Ankles?                            | <input type="radio"/> | <input type="radio"/> | Ankles?                     | <input type="radio"/> | <input type="radio"/> |
| Feet?                              | <input type="radio"/> | <input type="radio"/> | Feet?                       | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

# Arms & Hands

Check only if the answer is YES

- |                                    |                       |                       |                             |                       |                       |
|------------------------------------|-----------------------|-----------------------|-----------------------------|-----------------------|-----------------------|
| 1. Do you suffer with pain in the: | LT                    | RT                    | 2. Have you had surgery to: | LT                    | RT                    |
| Shoulder?                          | <input type="radio"/> | <input type="radio"/> | Shoulder?                   | <input type="radio"/> | <input type="radio"/> |
| Elbow?                             | <input type="radio"/> | <input type="radio"/> | Elbow?                      | <input type="radio"/> | <input type="radio"/> |
| Arm?                               | <input type="radio"/> | <input type="radio"/> | Arm?                        | <input type="radio"/> | <input type="radio"/> |
| Hands?                             | <input type="radio"/> | <input type="radio"/> | Hands?                      | <input type="radio"/> | <input type="radio"/> |

3. Have you ever been diagnosed with diabetes? \_\_\_\_\_

Do you have any special concerns or are there any details related to the information above?

**Procedure:** You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.

**Patient Disclosure:** I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

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



# *Acupuncture & Natural Healing Center*

Barbara Thurman, A.P., D.O.M, C.C.T

Nationally Certified Florida Licensed

Acupuncture Physician

Certified Clinical Thermographer

**Patient Information:** Breast Screening with Digital Infrared Thermal Imaging (DITI) - Thermography.

**Purpose of the Test:** Early Detection of abnormal changes in the breasts.

**Who Performs the Test:** A Certified Clinical Thermographer

**Patient Preparation:**

**Do not** smoke for 2 hours before the test, **do not** use lotions or powder on your body the day of your test, avoid sun exposure on the day of the test. **Do not** wear deodorant or antiperspirant. **Do not** have massage, physical therapy, saunas, hot tub 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 the surgical gown supplied. Inform you thermographer if you have had any recent skin lesions on your chest; the inflammation can cause a false positive result.

**How the test will feel:** The room air may feel cool on your body as you adjust to room temperature before scanning. Thermography is a totally non-invasive procedure; the camera does not emit radiation of any kind.

Please be on time for your appointment and bring your completed paperwork with you. Make sure you have explained any relevant questions on the back of your forms.

*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.*