Illinois Thermography

Client Information Sheet for RESCAN

Date of Birth /Age /Gender _____ _____ Date:_____

Client Name _____

Address _____ _____City _____Zip_____

Best Phone # _____ Best Email _____

Occupation: _____

Primary care Physician: _____

Current Symptoms : _____

_____

Current treatments :_____

Current Medications: _____

Thermogram Hx:_____

Previous report#_____

Result of clinical correlation:_____

Family history of breast cancer? Y _____ N_____

Last Mammogram/Ultrasound: _____ Result:_____

Family Hx:(If living, **age** and state of health, if deceased, **age** and **cause** of death)

Mother_____

Father_____:

Siblings:_____

_____

Ob/Gyn hx:_____

Surgical hx:_____

_____

Dental hx: Wisdom teeth removal? Root cannals? Crowns/bridges? Fillings? White silver extraxcted teeth? Implants? Braces? What age?

General hx:_____

Diagnoses:_____

Skin Lesions & Physical abnormalities: _____

Changes since last sca

Breast Thermography Confidential Questionnaire

	Yes	No	
1. Do you have any close relative who has had breast cancer?	___	___	
2. Have you ever been <u>diagnosed</u> with breast cancer?	___	___	**L R Date_____**
3. Ever been diagnosed with any other breast disease (fibrocystic)?	___	___	
4. Have you had any <u>biopsies or surgeries</u> to your breasts?	___	___	**L R Date _____**
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?	___	___	**# of years _____**
10. Have you suffered with cancer of the womb?	___	___	
11. Have you had hormone replacement therapy?	___	___	**# of years _____**
12. Do you have an annual physical examination by a doctor?	___	___	
13. Do you perform a monthly breast self exam?	___	___	
14. Did your period started before age 12?	___	___	
15. Did your period finished after age 50?	___	___	

16. How many mammograms have you had in total? _____

17. What was your age when you had your first mammogram? _____

18. How many children did you give birth to? _____Your age at birth of first child:_____

19. Do you smoke? Yes: ____Never: ____ Not in last 12 months: ___ Not in last 5 years: ____

Had vaccination in past 4 weeks? Indicate which arm	**Left Arm**	**Right Arm**	**No**
	O	**O**	**O**

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	____	_____

ILLINOIS THERMOGRAPHY, LLC

Authorization to Use or Disclose Protected Health Information

Date:_____/_____/_____

Client Name:_____ Date of Birth:_____/_____/_____

As required by the Privacy Regulations, Illinois Thermography, **LLC** may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

***I hereby request and authorize Illinois Thermography, LLC and any of its employees to use and release the themal images and related health histoy for the interepretation of said to:**

EMI, Electronic Medical Interpretations

***OPTIONAL - I hereby request and authorize Illinois Thermography, LLC and any of its employee to release all healthcare information to MY DOCTOR. ($5 paper copy)**

Name/Facility:_____

Address_____

City:_____State_____Zip code:_____

I request my Report and Images be sent to ME:

_____Via email on a PDF Report (NO CHARGE) email address:_____
(I am aware that my email is not secure and willing to accept the report using this method.)

_____Forward a copy of my scan to **the practitioner where I had** my scan /e-mail_____

_____Via Paper copy by US Mail **($5.00 charge applies)**

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Client's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED