Illinois Thermography

Client's Information Sheet (New and Re-scan clients)

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.

Date Of Birth /Age / Gender _____Date _____

Name _____

Address _____ **City**_____**State**____**Zip**_____

Best Phone # _____ **Best E-mail** _____

Occupation: _____

Primary Care Physician :_____

Referring Physician : _____

Clinical Concerns: _____

Current Symptoms(briefly describe your primary complaints or symptoms):_____

_____

Current Treatment:_____

Current Medication:_____

Thermogram History: __for office only_____

Results of clinical correlation:(Have you had any studies/test as a result of findings on your last thermogram?) _____

Surgical History: (include date possible):_____

_____

Dental history: Wisdom teeth removal? 1 2 3 4 Root cannals? Crowns/bridges?

Fillings? White silver Extraxcted teeth? Implants? Braces? What age?

General health? excellent good fair poor

_____

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

Mother:_____

Father:_____

Siblings: Sister(s)? / Brother(s)? age, health condition

_____
_____
_____

Diagnoses for you:_____

_____

Skin Lesions or Physical Abnormatilies: (scars, moles, piercing, scoliosis, pumps/ports)

_____

Female clients only:

Last Ob/Gyn+History:_____

Last Mammogram/ Breast Ultrasound +History:

<u>If diagnosed with Breast Cancer</u>

Cancer type:_____

Metastatic:_____ Local:_____Lymph involvement:_____

When diagnosed: Month:_____ Year: _____

Which breast and location in the breast : _____

Treatmet: Yes/No

Surgery_____Chemo_____Radiation _____ Other_____

<u>Diagnosed with other breast disease</u>

Fibrocystic: _____Cystic:_____Mastitis: _____ Abscess: _____Other:_____

<u>Breast biopsies or Surgery</u>

Which breast and location in the breast? _____

***Reason for screening today:*_____**

Name: **DOB:**

Breast Thermography Confidential Questionnaire

	Yes	No	
1. Do you have any close relative who has had breast cancer?	___	___	**(who?up to grandparents)**
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: ____

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

CLIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I 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 discussed in the Report.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

_____ _____

Signature: Date:

Authorization to Use or Disclose Protected Health Information

Illinois Thermography, LLC

Patient Name**:**_____

Address: _____

Date of Birth: _____ Date of Request**:**_____

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 authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)-
Interpretation of said images -

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

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

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.
7. 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 Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized Signature of Facility *Date*