Midwest Thermography

Patient History

Name_____ Email address_____

Social Security #:_____ - _____ - _____ Date of Birth:_____/_____/_____ Age_____

Marital: M S W D No. of Children_____

Address_____

City _____ State_____ ZIP_____

Home Phone_____ Work Phone_____

Occupation_____ Employer_____

Spouse's Name_____ Spouse's Employer_____

How were you referred to our office?_____

Previous themogram: Yes____ No____ Date of last thermogram _____ Location _____

Current medical doctor:_____ Current chiropractor:_____

Do you want a copy of the thermogram report forwarded to your medical doctor? ____Yes ____No

Current health problems: _____

_____

_____

Previous illnesses:_____

_____

Previous surgeries:_____

_____

Current medications:_____

_____

Current medications:_____

This information is confidential. All information is correct to my knowledge.

Signature _____ Date _____

Midwest Thermography

Full Body Study Questionnaire

Name _____ Date of Birth___/___/_____

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Please show areas of:

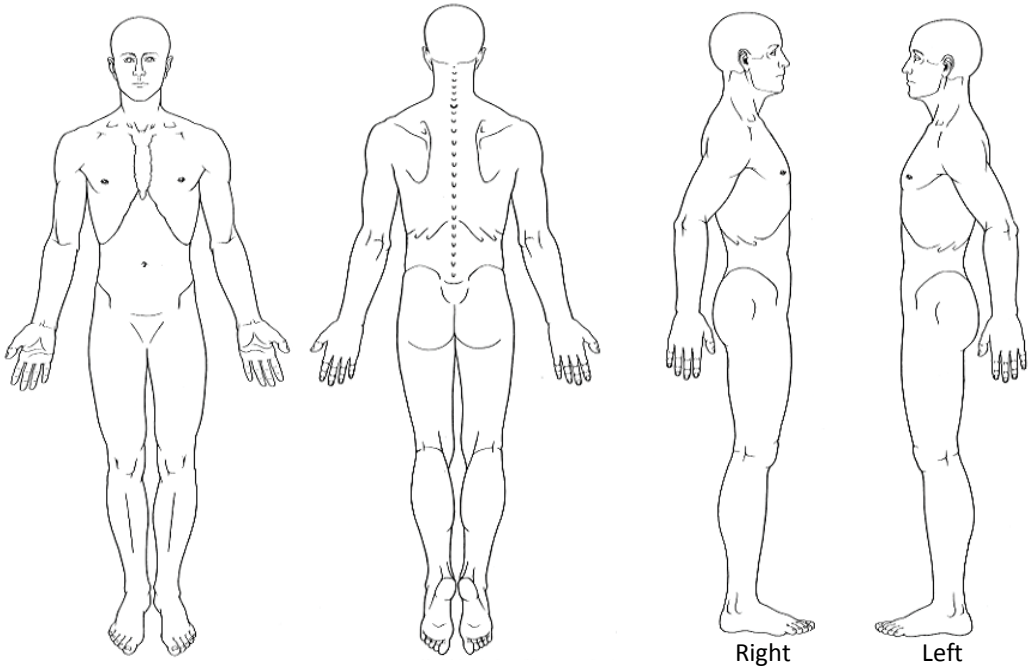
Primary pain *

Secondary pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions/scaring ∿∿



For areas of pain:

Do you know what triggered the pain? :_____

Does anything relieve it? _____

Does anything aggravate it? _____

Has is 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 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 of the areas 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 _____

Midwest Thermography

Breast Thermography Confidential Questionnaire

Name _____ Date of Birth___/___/_____

All information given in the questionnaire will remain strictly confidential and will only be divulged to thereporting thermologist and any other practitioner that you specify.

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
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?	☐	☐
10. Have you suffered with cancer of the womb?	☐	☐
11. Have you had pharmaceutical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

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

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

16. How many births have you had? _____Your age at birth of first child: _____

17. Did your periods start before the age of 12? Or finish after the age of 50? _____

18. Do you smoke? Yes___ Never___ Not in last 12 months___ Not in 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 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 _____

Midwest Thermography

Extended Breast Questionnaire

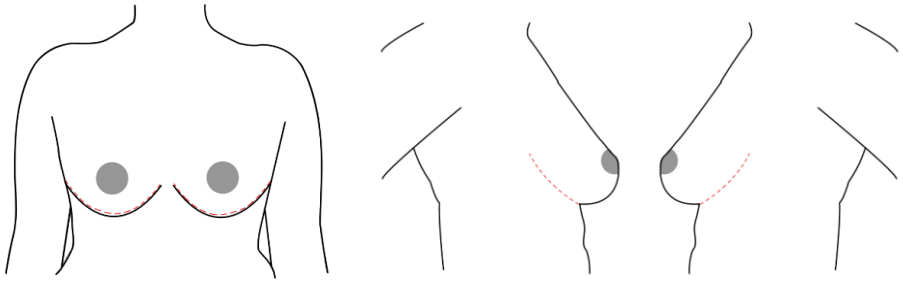
Name: _____ Date of Birth:___/___/_____

Diagnosed with breast cancer: Yes ___ No___

Cancer type: Metastatic ____ Local ____ Lymph node involvement ____

Diagnosis date: _____ _____
Month Year

Please mark the location of cancer:

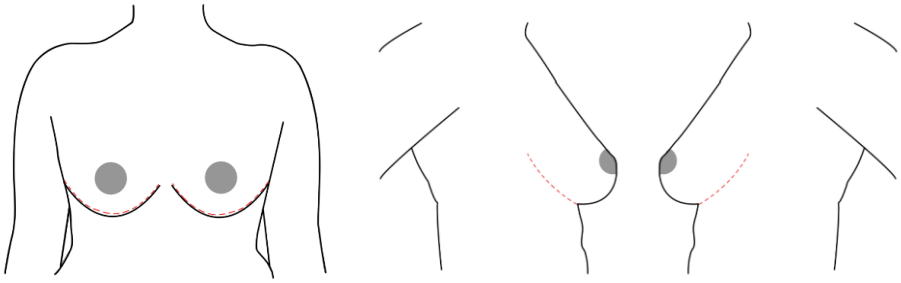


Right Left

Diagnosed with other breast disease: Yes ___ No___

Disease type: Fibrocystic ____ Cystic ____ Mastitis ____ Abscess ____ Other ____
(please report other types of disease in history)

Please mark the location of disease:



Right Left