



BREAST HISTORY

Date of Study: _____

Scan ID#: _____

Name: _____
Last First Middle

Address: _____
Number Street City State Zip Code

Phone: _____ Date of Birth: _____ Sex: M F Age: _____ Weight: _____

Physicians Name: _____ MD DO NMD

Physician's Address: _____
Number Street City State Zip Code

- Have you had a previous thermology study? Yes No
Date: _____ Name of Clinic: _____
- How many times have you been diagnosed with breast cancer? _____ Which side? Left Right
When was biopsy done? _____ What stage? 0 1 2 3 4 unknown
What type? Ductal Lobular Inflammatory Paget's Phyllodes Don't recall
What surgery did you undergo? None Lumpectomy Mastectomy
Date of surgery: _____
What treatment did you receive? None Radiation Chemotherapy
Date of your last treatment: _____
Provide the type of reconstructive surgery you had: None DIEP Lat Dorsi flap SGAP
TRAM flap Autologous fat graft Implant Other _____
Date of surgery: _____
- How many times have you had non-cancer breast surgery? This includes cosmetic surgery (implants, reduction, lift), all non-cancerous biopsies, aspirations and any other cosmetic surgery.
_____ Which side? Left Right Date of surgery (surgeries): _____

Type of surgery: Aspirations Biopsy Implants Lift Reduction Other: _____
- How many times have you had any abnormal results from breast testing? ___ Date(s) _____
Which side? Left Right Type of test: Physical Mammogram Ultrasound MRI



THERMA-SCAN

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5. How many times have you been diagnosed with any type of non-cancer breast disease ? _____
What disease were you diagnosed with? Fibro-Cystic Mastitis Dense Other: _____
Which side? Left Right Date of diagnosis: _____
6. How many times have you been diagnosed with ovarian cancer? _____
Date of Diagnosis: _____ Stage: 1 2 3 4 Date of last treatment: _____
7. Have you had surgery for the removal of both ovaries? Yes No Date of surgery: _____
8. Have you ever had radiation treatments to your back or chest **not including chest x-rays or CT scans**? Yes No Date of last treatment: _____
9. Have you gained more than 30 lbs since completing menopause? Yes No N/A
10. Have any of your blood relatives been diagnosed with breast or ovarian cancer? Yes No
Mother Daughter Sister(s) Aunt(s) Cousin(s) Grandmother(s) Niece(s)
Other: _____ Were they diagnosed at the age of 40 or younger? Yes No
11. Have you ever had a mammogram? Yes No Age of first mammogram: _____
How many mammograms have you had? _____ Date of last mammogram: _____
12. What was your age at first menstrual period: _____
13. Have you had an endometrial ablation? (A procedure that destroys the uterine lining or endometrium). This does not include a D & C. Yes No Date: _____
14. Has it been 12 months or more since your last menstrual period? Yes No
Date of last period: _____ Were you age 55 or older on the date of last period? Yes No
15. Have you ever used hormone contraceptives? Yes No What age did you start taking them? _____
How many years did you take them? _____
Did you use them for 4 or more years before your first child? Yes No
16. In the past 3 months, have you taken the following: Hormone contraceptives or prescribed hormone replacement therapy (HRT) **containing Estrogen** or do you currently have an IUD in place?
Yes No
If yes, what is the name of the medication? _____
17. Have you taken prescribed estrogen (HRT) for 4 or more years after menopause? Yes No



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18. Have you ever been pregnant? Yes No What was the age at your first pregnancy? _____
Have you ever given birth? Yes No Age at first childbirth: _____
Did you breast feed any of your children for more than six months? Yes No

19. Are you pregnant now? Yes No

20. Are you currently breast feeding? Yes No How many months have you been breast feeding?
_____ If any, which breast do you favor when feeding? Left Right Equal

21. In the nipple area have you had any of the following symptoms in the past six months? Pain
Tenderness Lumps Other symptoms: _____

22. Has a mammogram ever revealed that you have dense breasts? Yes No
If yes, what category? C D

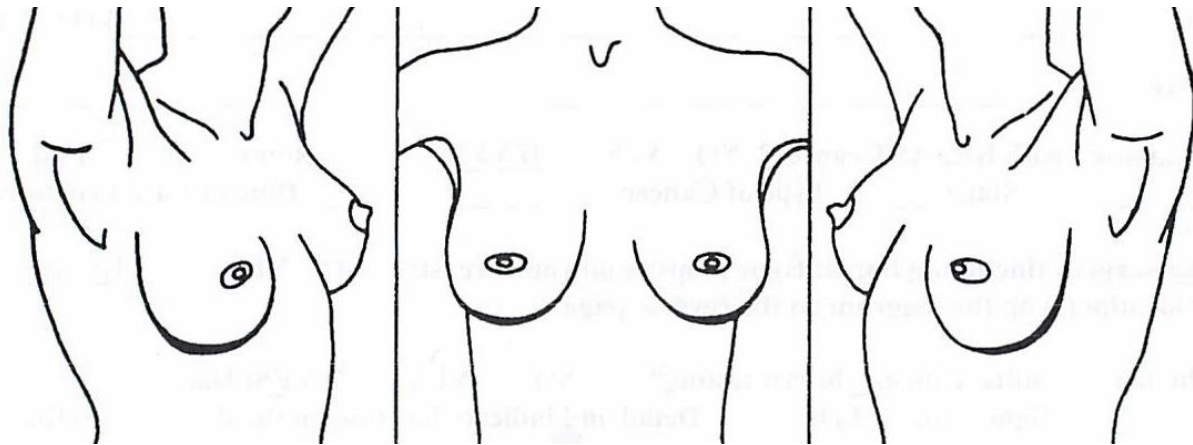
Please indicate the symptoms that you have experienced in the past 6 months and indicate the specific area(s) related to your symptom(s) on this drawing.

Right Breast: Pain Tenderness Lumps Skin Thickening Discoloration Changes in Shape
Changes in Size Rash

Right Nipple: Discharge Discoloration

Left Breast: Pain Tenderness Lumps Skin Thickening Discoloration Changes in Shape
Changes in Size Rash

Left Nipple: Discharge Discoloration



Tech Notes:



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Patient Name: _____

Informed Consent and Release:

Your signature below will acknowledge that you have been offered, read and understand the Thermascan Reference Laboratory, LLC. Privacy Practices, Informed Consent, Authorization and Report Release; that you consent to the thermology procedure and instruct us to release your thermology report to the physician(s) and others you have specified on this form. Your signature also indicates you have complied with the preparation protocols as instructed.

Do you consent to the terms above? YES NO

With this release you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information.

Do you consent to the terms above? YES NO

Signature _____ Date _____