

Y N

- 9. Have you ever had any biopsies or any other surgeries to your breasts? Y N
 If yes, date _____
 Left breast Inner Outer Nipple
 Right breast Inner Outer Nipple
 Results Negative Positive Calcifications
- 10. Have you ever taken contraceptive pills for more than one year? Y N
 If yes, Currently Less than 5 years More than 5 years
- 11. Have you had pharmaceutical hormone replacement therapy (HRT)? Y N
 If yes, Currently Less than 5 years More than 5 years
- 12. Do you have an annual physical examination by a doctor? Y N
- 13. Do you perform a monthly breast self exam? Y N
- 14. Have you ever smoked? Y N
- 15. Have you ever been diagnosed with diabetes? Y N
- 16. Date of your last mammogram _____ Were you re-called? _____ Y N
- 17. How many mammograms have you had in total? _____
- 18. Your age at your first mammogram? _____
- 19. Number of full term pregnancies? _____
- 20. Your age at birth of your first child? _____
- 21. Age when you started your period? _____

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 _____ Today's Date _____