eLEEEte PHYSICIANS, LLC

Confidential Questionnaire

Female *Full Body*

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cellular)_____(work)_____

E-Mail Address_____

Referring Physician_____

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.

Head & Neck

	Yes	No
1. Do you suffer with headaches?	○	○
If yes, ○ once a month or less ○ more than once a month		
2. Do you have allergies?	○	○
3. Do you have TMJ or does your jaw click?	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder?	○	○
6. Do you have neck pain?	○	○
7. Do you have upper back pain?	○	○
8. Do you have a history of carotid artery disease?	○	○
9. Do you have a family history of stroke?	○	○
10. Do you currently suffer with sinus problems?	○	○

Do you have any special concerns or are there any details related to the information above?

Breast

Is there a specific reason or concern for your exam?

	Yes	No
1. Have you recently had any of these breast symptoms?	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin thickening or dimpling	○	○
Excretions of the nipple	○	○

2. Are any of the above symptoms cycle related? ○ Yes ○ No

3. Are you still having periods? ○ Yes ○ No
   If yes, date of last period_____

4. Have you had a surgical hysterectomy? ○ Yes ○ No
   If yes, date_____ ○ Complete ○ Partial
   Reason for hysterectomy?
   ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? ○ Yes ○ No
   If yes, ○ Mother ○ Grandmother ○ Sister ○ Daughter
   If yes, Age disgnosed_____ survived: Yes_____No_____

6. Have <u>you</u> ever been diagnosed with breast cancer? ○ Yes ○ No
   If yes, date_____

Cancer type	○ Local	○ Metastatic	○ Lymph node involvement	
Left breast	○ Inner	○ Outer	○ Nipple	
Right breast	○ Inner	○ Outer	○ Nipple	
Treatment	○ Surgery	○ Chemo	○ Radiation	○ None

7. Have you ever been diagnosed with any other breast disease? ○ Yes ○ No
   If yes, ○ Cysts/fibrocystic ○ Mastitis/inflammatory breast disease
   ○ Fibro Adenoma

8. Have you had any cosmetic breast surgery or implants? ○ ○

If yes, date_____ ○ Silicone ○ Saline

Experience ○ Problems ○ No problems

9. Have you ever had any biopsies or any other surgeries to your breasts? ○ ○

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? ○ ○

If yes, ○ Currently ○ Took for less than 5 years ○ Took for more than 5 years

11. Have you had pharmaceutical hormone replacement therapy (HRT)? ○ ○

If yes, ○ Currently ○ Taken less than 5 years ○ Taken more than 5 years

12. Do you have an annual physical examination by a doctor? ○ ○

13. Do you perform a monthly breast self exam? ○ ○

14. Have you ever smoked? ○ ○

15. Have you ever been diagnosed with diabetes? ○ ○

16. Date of your last mammogram_____ Were you re-called?_____ ○ ○

17. How many mammograms have you had in total?_____
18. Your age at your first mammogram?_____
19. How many 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?

Chest, Heart & Lungs

	Yes	No
1. Have you ever been diagnosed with:		
Heart disease?	○	○
Lung disease?	○	○
Upper spine disorders?	○	○
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
4. Have you ever had surgery to:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
5. Do you have asthma or shortness of breath?	○	○
6. Do you currently smoke?	○	○
7. Have you smoked in the last 5 years?	○	○

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

	Yes	No
1. Do you suffer with acid reflux?	○	○
2. Do you have pain in the:		
Stomach?	○	○
Below the right breast?	○	○
Below the left breast?	○	○
Abdomen?	○	○
Lower back?	○	○

	Yes	No
3. Have you had surgery or disease in the:		
Stomach?	○	○
Spleen? Left upper quadrant	○	○
Liver? Right upper quadrant	○	○
Kidneys?	○	○
Intestines?	○	○
Abdomen?	○	○
Lower back?	○	○

Do you have any special concerns or are there any details related to the information above?

Legs and Feet

(Check only if "yes")

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Leg?	○	○	Leg?	○	○
Sciatica?	○	○	Sciatica?	○	○
Buttocks/Hip?	○	○	Buttocks/Hip?	○	○
Knees?	○	○	Knees?	○	○
Ankles?	○	○	Ankles?	○	○
Feet?	○	○	Feet?	○	○

Do you have any special concerns or are there any details related to the information above?

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Shoulder?	○	○	Shoulder?	○	○
Elbow?	○	○	Elbow?	○	○
Arm?	○	○	Arm?	○	○
Hands?	○	○	Hands?	○	○

	Yes	No
3. Have you ever been diagnosed with diabetes?	○	○

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_____