eLEEte PHYSICIANS, LLC

Confidential Questionnaire

Women's Health Screening

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 this breast 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	○	○

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	Yes	No
2. Are any of the above symptoms cycle related?	○	○
3. Are you still having periods?	○	○
If yes, date of last period_____		
4. Have you had a surgical hysterectomy?	○	○
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?	○	○
If yes, ○ Mother ○ Grandmother ○ Sister ○ Daughter		
If yes, Age diagnosed_____ survived: Yes_____No_____		
6. Have you ever been diagnosed with breast cancer?	○	○
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?	○	○
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 ○ Less than 5 years ○ More than 5 years		
11. Have you had pharmaceutical hormone replacement therapy (HRT)?	○	○
If yes, ○ Currently ○ Less than 5 years ○ 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. Number of full term pregnancies?_____

20. Your age at birth of your first child?_____

21. Age when you started your period?_____

Chest, Heart & Lungs

	Yes	**No**
1. Have you 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 your:		
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 past 5 years?	○	○

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_____

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