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**Extended Breast Questionnaire**

**Diagnosed with breast cancer**

**Cancer type:** Metastatic Local Lymph node involvement

**When diagnosed:** Month Year

**Where (left breast): UO UI LO LI** Nipple

**Where (right breast): UO UI LO LI** Nipple

**Treatment:** Surgery Chemo Radiation Other None

**Diagnosed with other breast disease:**

**Disease type:** Fibrocystic Cystic Mastitis Abscess Other

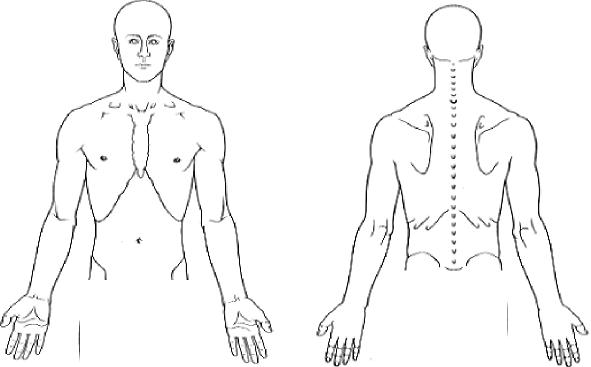
(please report other types of disease in the history)

**Breast biopsies or surgery:**

**Where (left breast): UO UI LO LI** Nipple

**Where (right breast): UO UI LO LI** Nipple

**Name: D.O.B:**





**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.**

**Upper Body Study Questionnaire**

**Address:**

**Phone. Your Doctor:**

**Please Show areas of :**

Main Pain

Secondary Pain 0

Numbness ////////

Pins and needles

Skin lesions / scaring

**Do you know what triggered the pain ?**

**Does anything relieve it ?**

**Does anything aggravate it ?**

**Has it 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**

**Previous Illnesses.**



**Patient Information Sheet.**

**Name D 0 B**

**Address**

**Phone (H) (W)**

**Occupation**

**Previous Surgery.**

**Current Health Problems.**

**Medication**

**Other Treatment**

**Current Doctor.**

**Do you want a copy of the thermogram report forwarded to your doctor ?**

**Yes No**

**This information is confidential.**

**All information is correct to my Knowledge.**

**Signed Date**