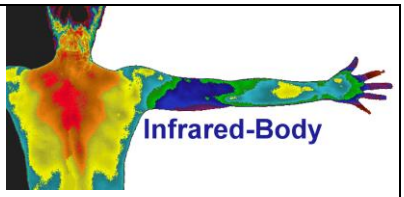
Mobile Medical Thermography Imaging
Confidential Questionnaire



Women's Full Body Study

Name_____ Birth Date_____

Address_____ City_____ State_____ Zip_____

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

Email_____ Referral?_____

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 known allergies? Food ____ Environmental___	___	___
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? Type_____	___	___
6. Do you have neck pain?	___	___
7. Do you have upper back pain?	___	___
8. Do you have a known history of carotid artery disease?	___	___
9. Do you have a family history of stroke?	___	___
10. Do you currently suffer with sinus problems?	___	___
11. Do you have history of dental problems?	___	___
Root canals ____ Gum disease ____ Implants ____		
Non-replaced extractions ____ Dentures ____		
12. Have you had dental cleaning in the past 7 days?	___	___

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? (Mark only if "yes")	___	___

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

2. Are any of the above symptoms cycle related? ___ ___

3. Are you still having your periods? ___ ___

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, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter

   Age diagnosed _____ Result of Treatment_____

6. Have you ever been diagnosed with breast cancer? ___ ___

   If yes, date Month _____Year_____

   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 ___ Fibro Adenoma ___

   Mastitis/inflammatory breast disease ___

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 ___ ___

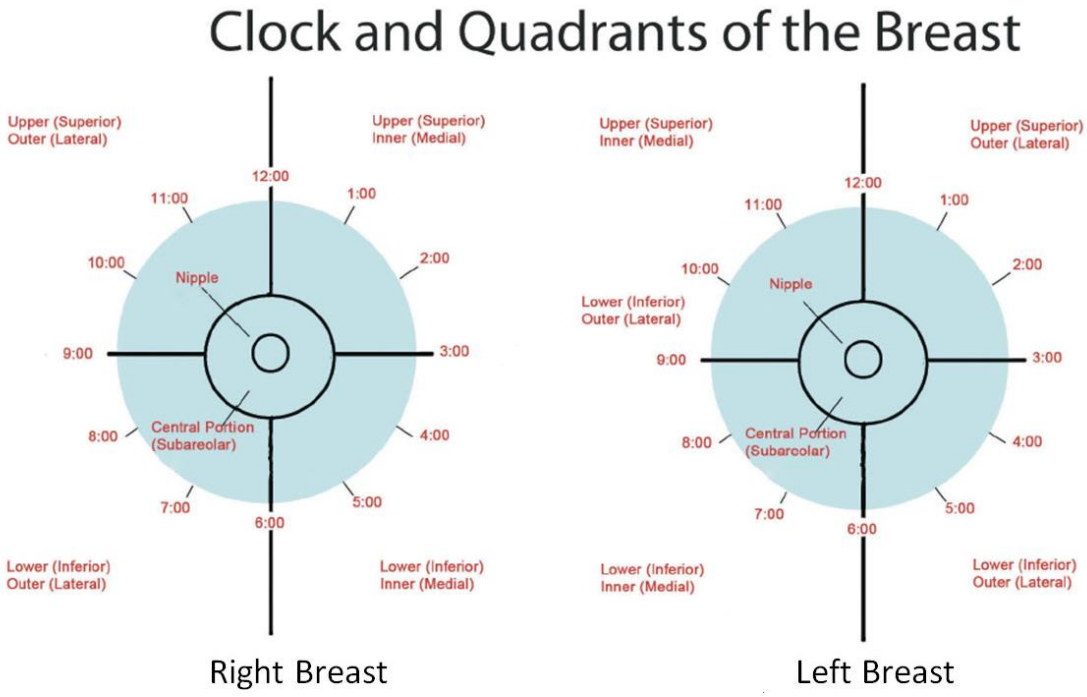
   If yes, date_____

   Left breast ○ Inner ○ Outer ○ Nipple

   Right breast ○ Inner ○ Outer ○ Nipple

   Results ○ Negative ○ Positive ○ Calcifications

Mark on the following graph to indicate location of pain, surgery or lumps:



	Yes	No
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. Total mammograms____		
17. Date of last mammogram _____ Were you re-called?	___	___
18. Your age at your first mammogram: _____		
19. Number of full term pregnancies: _____		
20. Have you had breast ultrasound? If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___	___	___
21. Have you had breast MRI? If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___	___	___

Chest, Heart & Lungs

1. Have you been diagnosed with:	Yes	No
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?	___	___

Abdomen & Lower Back

1. Do you suffer with acid reflux or other digestive problems? Yes___ No___	Have you had surgery or disease in the:
2. Do you suffer pain in the:	Stomach? Yes___ No___
Stomach? Yes___ No___	Spleen(Upper Left) ? Yes___ No___
Below R Breast? Yes___ No___	Liver(Upper Right) ? Yes___ No___
Below L Breast? Yes___ No___	Kidneys ? Yes___ No___
Abdomen? Yes___ No___	Intestines ? Yes___ No___
Lower Back? Yes___ No___	Abdomen ? Yes___ No___
Pelvic Region? Yes___ No___	Lower Back? Yes___ No___
	Pelvic Region? Yes___ No___

Have you consumed alcohol in the past 24 hours? Yes___ No___

Legs & Feet - Check only if "yes"

1. Do you suffer **pain** in the:	2. Have you had **surgery** to:
Leg? LT___ RT ___	Leg? LT___ RT ___
Sciatica? LT___ RT ___	Sciatica? LT___ RT ___
Buttocks/Hip? LT___ RT ___	Buttocks/Hip? LT___ RT ___
Knee? LT___ RT ___	Knee? LT___ RT ___
Ankle? LT___ RT ___	Ankle? LT___ RT ___
Feet? LT___ RT ___	Feet? LT___ RT ___

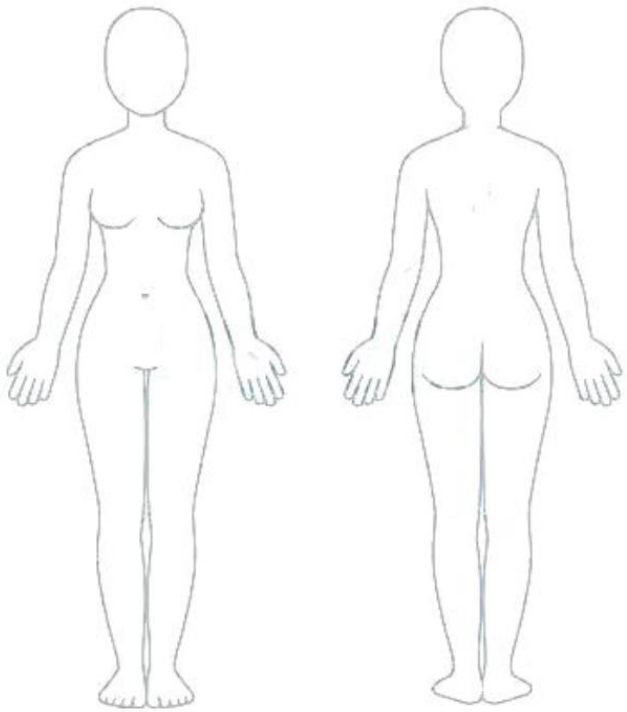
Arms & Hands - Check only if "yes

1. Do you suffer **pain** in the:		2. Have you had **surgery** to:	
Shoulder?	LT___ RT ___	Shoulder?	LT___ RT ___
Elbow?	LT___ RT ___	Elbow?	LT___ RT ___
Arm?	LT___ RT ___	Arm?	LT___ RT ___
Hand?	LT___ RT ___	Hand?	LT___ RT ___

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

Areas of Pain

Mark on the following graph to indicate location of pain, surgery or injury:



Areas of Pain

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

Client Disclosure

Breast thermography is a non-contact, private and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes**. It offers men and women information that no other procedure can provide regarding breast health.**

Breast thermography is not a replacement for or alternative to mammography or any other form of breast imaging. Breast thermography, mammography or breast ultrasounds are complementary procedures; one **test does not replace the other.** Breast thermography is meant to be used in addition to other tests or procedures.

Thermography captures and records temperature variations on the skin, which provides vital information directly influenced by complex metabolic and vascular activity. This information **does not in any way suggest diagnosis and/or treatment**. Studies show that the patient benefits when multiple tests are used together. This multimodal approach includes breast self-examinations, physical breast exams by a doctor, mammography, ultrasound, MRI, thermography, and other tests that may be ordered by your doctor. ***A reported "Elevated Level of Concern" finding does not indicate that it is suspicious for any specific disease.*** However, any suspicious finding will be accompanied with a strong and intentional recommendation for further clinical evaluation. If you detect a lump or any other change in your breast before your next thermogram study, consult your doctor immediately.

Notice to clients presenting with previously diagnosed cancer: Thermography interpretation in your report **does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns**. As there is no single known test capable of monitoring all biological influences of the complex disease generally diagnosed as cancer, **continued monitoring with available additional testing as recommended by your personal physician is strongly advised. Your Thermographer cannot interpret your images or advise or prescribe to you based on your images.** Your thermographer can ask health history questions as well as educate you on general breast health.

By Signing below, I certify that I have read and understand the statement above and consent to the Women's Full Body Study.

Client Signature _____Today's Date_____