

Breast Questionnaire

Name: _____ Birthdate: _____

- | | | |
|---|-----|----|
| 1. Do you have any close relative who has had breast cancer? | Yes | No |
| 2. Have you ever been diagnosed with breast cancer? | Yes | No |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)? | Yes | No |
| 4. Have you had any biopsies or surgeries to your breasts? | Yes | No |
| 5. Have you had any breast cosmetic surgery or implants? | Yes | No |
| 6. Have you had a mammogram in the past 12 months? | Yes | No |
| 7. Have you had a mammogram in the past 5 years? | Yes | No |
| 8. Have you had abnormal results from any breast testing? | Yes | No |
| 9. Have you ever taken a contraceptive pill for more than 1 year? | Yes | No |
| 10. Have you suffered with cancer of the womb? | Yes | No |
| 11. Have you had pharmaceutical hormone replacement therapy? | Yes | No |
| 12. Do you have an annual physical examination by the doctor? | Yes | No |
| 13. Do you perform a monthly breast self exam? | Yes | No |
| 14. How many mammograms have you had in total? _____ | | |
| 15. What was your age when you had your first mammogram? _____ | | |
| 16. How many births have you had? _____ Your age at birth of first child: _____ | | |
| 17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____ | | |
| 18. Do you smoke? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__ | | |

Have you recently had any of these breast symptoms:

Right Breast **Left Breast**

- | | | |
|--------------------------------------|--------------------------|--------------------------|
| Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Tenderness | <input type="checkbox"/> | <input type="checkbox"/> |
| Lumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in breast size | <input type="checkbox"/> | <input type="checkbox"/> |
| Areas of skin thickening or dimpling | <input type="checkbox"/> | <input type="checkbox"/> |
| Secretions of the nipple | <input type="checkbox"/> | <input type="checkbox"/> |

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 discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature _____ Today's Date _____