WHOLISTIC Thermography

Breast Questionnaire

Name: _____ Birthdate: _____

1. Do you have any close relatives who have 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 dense)? ☐ 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 any 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 ever suffered with cancer of the womb? ☐ Yes ☐ No
11. Have you had pharmaceutical hormone replacement therapy? (or Bio-identical hormone replacement therapy?) ☐ Yes ☐ No
12. Do you have an annual physical examination by a doctor? ☐ Yes ☐ No
13. Do you perform a monthly breast exam? ☐ Yes ☐ No

1. How many mammograms have you had in total? _____
2. What was your age when you had your first mammogram? _____
3. How many births have you had? _____ YOUR age at the birth of your first child: _____
4. Did your periods start before the age of 12?_____ Or finish after the age of 50? _____
5. Do you smoke? Yes☐ No☐ Never☐ Not in the last 12 months☐ Nor in last 5 years☐
6. Have you had a COVID vaccination in the past 30 days? Yes☐ No☐ Right arm☐ Left arm☐

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Breast Questionnaire

HAVE YOU RECENTLY HAD ANY OF THESE BREAST SYMPTOMS?	RIGHT BREAST	LEFT BREAST
Pain?	☐	☐
Tenderness?	☐	☐
Lumps?	☐	☐
Change in Breast Size?	☐	☐
Areas of Skin Thickening or Dimpling?	☐	☐
Secretions of the Nipple?	☐	☐

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.

Signed:_____ Date: _____