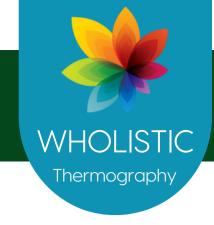


Breast Questionnaire

Name: Birtho	date:	
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	Yes	No
replacement therapy?)		
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	n	



Breast Questionnaire

HAVE YOU RECENTLY HAD ANY OF THESE BREAST SYMP	PTOMS? 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 in evaluation, diagnosis, and treatment. I further understand that the Report is or self-diagnosis. I understand that the Report will not tell me whether I have a analysis of the Images with respect only to the thermographic findings of the a that I have read and understand the statements above and consent to the example.	not intended to be used by indiviny illness, disease, or other conditions discussed in the Report. By s	duals for self-evaluation tion, but will be an
Signed:	Date:	

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