# Thermography Client Preparation and Recommendations

## Prior to the appointment, the client must be advised:

• No breast surgery, chemotherapy or radiation treatments 3 months prior.

• No breast biopsy for one month prior.

• Lactation: Imaging is recommended if there is a problem or concern, but a baseline is not recommended for at least 3 months after the last active breastfeeding.

## 24 Hours Prior

• Avoid exercise or heavy physical activity.

• No massage or lymph treatments.

• No chiropractic adjustments.

• No saunas, steam bath or hot tub.

• No hot or cold packs.

• Avoid spicy food 24 hours prior to imaging

• No Alcohol –*preferred*

## Day of Exam:

• Avoid deodorant or creams on the skin, especially oils.

• Absolutely no heat lamps or sunburn. You will have to reschedule.

• Do not shave area to be imaged.

• No food or drink 2 hours before imaging and no chewing gum.

• No coffee or cigarettes for at least 2 hours before imaging.

• Client must remove all jewelry in the area to be imaged.

Thermal Imaging Services
Phone: 713-621-4406
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# Thermography Informed Consent

I consent to a thermography procedure by a certified clinical thermographer on the staff of Thermal Imaging Services. I understand that a thermographer is a photographer and not trained nor educated to read the results of my thermogram. I have been informed that a radiologist or a medical doctor trained to read thermograms will read my thermogram and that I will be provided with the findings and images in a report form. I understand that thermography in no way replaces mammography, but rather is an adjunct procedure to a mammogram. I also understand that a biopsy is the only definite indicator for any high breast risks that might be present.

**Initial all that apply:**

_____ **I have <u>had</u> a mammogram(s) in the past and am choosing to have a thermogram today.**

_____ **I have <u>never</u> had a mammogram and am choosing to have a thermogram today.**

_____ **I have had a thermogram(s) in the past and am choosing to have a follow-up today.**

_____ **I understand that is <u>my</u> responsibility and decision to seek out further medical attention and undergo an ultra-sound, mammogram or biopsy if breast disease is indicated from a thermogram report.**

_____ **I understand that a thermogram examines the physiological processes of the body versus the anatomical aspects of the body. I am consenting to this procedure without any pressure from a staff member of Thermal Imaging Services.**

_____

**Client or Responsible Party Signature** **Date**

**Angel Marlow, CCT**

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***A photocopy of this document shall be considered as effective and valid as the original.***

**Thermal Imaging Services**
**24550 Kingsland Blvd. Katy,TX 77494**
**713-621-4406(office) – 713-589-8615(fax)**

# Confidential Questionnaire

# *Breast*

Name_____Birth Date_____Today's Date_____
Address_____City_____State_____Zip_____
Phone # Home_____Cellular_____Other_____
E-Mail Address_____
Referring Physician_____

Is there a specific reason or concern for this wellness scan?

| | |
|---|---|
| | |

| | 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? ○ ○
   If yes, date of last period_____

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_____
   _____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 |

Notes:_____
_____

| | Yes | No |
|---|---|---|
| 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 | | |
| 10. Have you ever taken contraceptive pills for more than one year? | ○ | ○ |
| If yes, ☐ Currently ☐ Less than 5 years ☐ More than 5 years | | |
| Total overall years taken_____ | | |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT/Bio Identical)? | ○ | ○ |
| If yes, ☐ Currently ☐ Less than 5 years ☐ More than 5 years | | |
| Name/Type of HRT? _____ Dates started/stopped _____ | | |
| Name/Type Bio-Identical_____ Dates started/stopped _____ | | |
| 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? | ○ | ○ |
| Did you go? _____ | | |
| 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 ____ | | |

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

***Procedure:*** *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

***Patient Disclosure:*** *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination.*

Patient Signature_____ Today's Date_____

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