



## **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.



## 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 had a mammogram(s) in the past and am choosing to have a thermogram today.

\_\_\_\_\_ I have never 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 my 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.

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**Client or Responsible Party Signature**

**Date**

Angel Marlow, CCT

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Angel Marlow, CCT

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

**Thermal Imaging Services  
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# Confidential Questionnaire

## Women's Health Screening

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number (home) \_\_\_\_\_ (cellular) \_\_\_\_\_ (work) \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Referring Physician \_\_\_\_\_

*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?  Yes  No  
 If yes,  once a month or less  more than once a month
2. Do you have known allergies? Food \_\_\_\_ Environmental \_\_\_\_  Yes  No
3. Do you have  TMJ or  does your jaw click?  Do you grind your teeth?  
 (Check all that apply)  Yes  No
4. Do you currently have a cold?  Yes  No
5. Are you being treated for a thyroid disorder? Type \_\_\_\_\_  Yes  No  
 What type of medication or supplement are you taking for Thyroid? \_\_\_\_\_
6. Do you have neck pain?  All the time  Occasional  Yes  No
7. Do you have upper back pain?  All the time  Occasional  Yes  No
8. Do you have a known history of carotid artery disease?  Yes  No
9. Do you have a family history of stroke?  Yes  No  
 Mom  Dad  Sibling  Grandparent (Maternal/Paternal)
10. Do you currently suffer with sinus problems?  Yes  No  
 Seasonal  All the time
11. Do you have history of dental problems?  Yes  No  
 Root canals \_\_\_\_ Gum disease \_\_\_\_ Implants \_\_\_\_  
 Upper/Lower- Right/Left Upper/Lower- Right/Left  
 Non-replaced extractions \_\_\_\_ Dentures \_\_\_\_  
 Upper/Lower- Right/Left
12. Have you had dental cleaning in the past 7 days?  Yes  No

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”)  Yes     No
- |  | <b>LT</b>             | <b>RT</b>             |
|--|-----------------------|-----------------------|
| Pain/Tenderness                              | <input type="radio"/> | <input type="radio"/> |
| Lumps  | <input type="radio"/> | <input type="radio"/> |
| Change in breast size                        | <input type="radio"/> | <input type="radio"/> |
| Areas of skin changes thickening or dimpling | <input type="radio"/> | <input type="radio"/> |
| Excretions or changes of the nipple          | <input type="radio"/> | <input type="radio"/> |
2. Are any of the above symptoms cycle related?  Yes     No
3. Are you still having your periods?  Yes     No  
 If yes, date of last period \_\_\_\_\_
4. Have you had a surgical hysterectomy?  Yes     No  
 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?  Yes     No  
 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?  Yes     No  
 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: \_\_\_\_\_  
 \_\_\_\_\_
7. Have you ever been diagnosed with any other breast disease?  Yes     No  
 If yes,     Cysts/fibrocystic     Fibro Adenoma     Mastitis/inflammatory breast disease
8. Have you had any cosmetic breast surgery or implants?  Yes     No  
 If yes, date \_\_\_\_\_     Silicone     Saline  
 Experience:     Problems     No problems

**Yes**      **No**

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

NOTES: \_\_\_\_\_

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?
- Total time smoked? \_\_\_\_\_
15. Have you ever been diagnosed with diabetes?
- When \_\_\_\_\_ List diabetes medication \_\_\_\_\_
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 \_\_\_

NOTES:

# Chest, Heart & Lungs

- |   | <b>Yes</b>            | <b>No</b>             |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with:                | <input type="radio"/> | <input type="radio"/> |
| Heart disease?                                  | <input type="radio"/> | <input type="radio"/> |
| Date of Diagnoses _____                         |                       |                       |
| Lung disease?                                   | <input type="radio"/> | <input type="radio"/> |
| Date of Diagnoses _____                         |                       |                       |
| Upper spine disorders?                          | <input type="radio"/> | <input type="radio"/> |
| Date Diagnosed _____                            |                       |                       |
| 2. Do you suffer with upper back pain?          | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain?               | <input type="radio"/> | <input type="radio"/> |
| Details/Location _____                          |                       |                       |
| 4. Have you ever had surgery to your:           |                       |                       |
| Heart?  | <input type="radio"/> | <input type="radio"/> |
| Lungs?  | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back?                              | <input type="radio"/> | <input type="radio"/> |
| List type of surgery and date _____             |                       |                       |
| 5. Do you have asthma or shortness of breath?   | <input type="radio"/> | <input type="radio"/> |
| 6. Do you currently smoke?                      | <input type="radio"/> | <input type="radio"/> |
| 7. Have you smoked in the past 5 years?         | <input type="radio"/> | <input type="radio"/> |
| Have you consumed alcohol in the past 24 hours? | <input type="radio"/> | <input type="radio"/> |

\*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 \_\_\_\_\_