



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.

Client or Responsible Party Signature

Date

Angel Marlow, CCT

Angel Marlow, CCT

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

Women's Comprehensive Full Body

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? Yes No
- 4. Do you currently have a cold? Yes No
- 5. Are you being treated for a thyroid disorder? Type _____ Yes No
- 6. Do you have neck pain? Yes No
- 7. Do you have upper back pain? 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
- 10. Do you currently suffer with sinus problems? Yes No
- 11. Do you have history of dental problems? Yes No
 Root canals ____ Gum disease ____ Implants ____
 Non-replaced extractions ____ Dentures ____
- 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?

- | | Yes | No |
|--|-----------------------|-----------------------|
| 9. Have you ever had any biopsies or any other surgeries to your breasts?
If yes, date _____
Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple
Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple
Results <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Calcifications | <input type="radio"/> | <input type="radio"/> |
| 10. Have you ever taken contraceptive pills for more than one year?
If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years | <input type="radio"/> | <input type="radio"/> |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)?
If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years | <input type="radio"/> | <input type="radio"/> |
| 12. Do you have an annual physical examination by a doctor? | <input type="radio"/> | <input type="radio"/> |
| 13. Do you perform a monthly breast self exam? | <input type="radio"/> | <input type="radio"/> |
| 14. Have you ever smoked? | <input type="radio"/> | <input type="radio"/> |
| 15. Have you ever been diagnosed with diabetes? | <input type="radio"/> | <input type="radio"/> |
| 16. Total Mammograms _____ | | |
| 17. Date of your last mammogram _____ Were you re-called? | <input type="radio"/> | <input type="radio"/> |
| 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 ____ | <input type="radio"/> | <input type="radio"/> |
| 21. Have you had breast MRI?
If yes...Date: ____/____ Left ____ Right ____ Results: Negative ____ Positive ____ | <input type="radio"/> | <input type="radio"/> |

Chest, Heart & Lungs

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with:
Heart disease?
Lung disease?
Upper spine disorders? | <input type="radio"/> | <input type="radio"/> |
| 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"/> |
| 4. Have you ever had surgery to your:
Heart?
Lungs?
Mid to upper back? | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |

Yes No

6. Do you currently smoke?

7. Have you smoked in the past 5 years?

Abdomen & Lower Back

		Yes	No			Yes	No
1. Do you suffer with acid reflux or other digestive problems?		<input type="radio"/>	<input type="radio"/>	Have you had surgery or disease in the:			
2. Do you suffer pain in the:				Stomach?		<input type="radio"/>	<input type="radio"/>
Stomach?		<input type="radio"/>	<input type="radio"/>	Spleen(Upper Left) ?		<input type="radio"/>	<input type="radio"/>
Below R Breast?		<input type="radio"/>	<input type="radio"/>	Liver(Upper Right) ?		<input type="radio"/>	<input type="radio"/>
Below L Breast?		<input type="radio"/>	<input type="radio"/>	Kidneys ?		<input type="radio"/>	<input type="radio"/>
Abdomen?		<input type="radio"/>	<input type="radio"/>	Intestines ?		<input type="radio"/>	<input type="radio"/>
Lower Back?		<input type="radio"/>	<input type="radio"/>	Abdomen ?		<input type="radio"/>	<input type="radio"/>
Pelvic Region?		<input type="radio"/>	<input type="radio"/>	Lower Back?		<input type="radio"/>	<input type="radio"/>
				Pelvic Region?		<input type="radio"/>	<input type="radio"/>

Have you consumed alcohol in the past 24 hours?

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	LT	RT	2. Have you had Surgery to:	LT	RT
Leg?	<input type="radio"/>	<input type="radio"/>	Leg?	<input type="radio"/>	<input type="radio"/>
Sciatica?	<input type="radio"/>	<input type="radio"/>	Sciatica?	<input type="radio"/>	<input type="radio"/>
Buttocks/Hip?	<input type="radio"/>	<input type="radio"/>	Buttocks/Hip?	<input type="radio"/>	<input type="radio"/>
Knees?	<input type="radio"/>	<input type="radio"/>	Knees?	<input type="radio"/>	<input type="radio"/>
Ankles?	<input type="radio"/>	<input type="radio"/>	Ankles?	<input type="radio"/>	<input type="radio"/>
Feet?	<input type="radio"/>	<input type="radio"/>	Feet?	<input type="radio"/>	<input type="radio"/>

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	LT	RT	2. Have you had surgery to:	LT	RT
Shoulder?	<input type="radio"/>	<input type="radio"/>	Shoulder?	<input type="radio"/>	<input type="radio"/>
Elbow?	<input type="radio"/>	<input type="radio"/>	Elbow?	<input type="radio"/>	<input type="radio"/>
Arm?	<input type="radio"/>	<input type="radio"/>	Arm?	<input type="radio"/>	<input type="radio"/>
Hands?	<input type="radio"/>	<input type="radio"/>	Hands?	<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 _____

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