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
Fax: 713-589-8615
info@thermalimagingtexas.com

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 Health Screening with Abdomen

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? If yes, ○ once a month or less ○ more than once a month	○	○
2. Do you have known allergies? Food ____ Environmental___	○	○
3. Do you have ○TMJ or ○does your jaw click? ○ Do you grind your teeth? (Check all that apply)	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder? Type____________ What type of medication or supplement are you taking for Thyroid?______________	○	○
6. Do you have neck pain? ○All the time ○Occasional	○	○
7. Do you have upper back pain? ○All the time ○Occasional	○	○
8. Do you have a known history of carotid artery disease?	○	○
9. Do you have a family history of stroke? ○Mom ○Dad ○ Sibling ○Grandparent (Maternal/Paternal)	○	○
10. Do you currently suffer with sinus problems? ○ Seasonal ○ All the time	○	○
11. Do you have history of dental problems? 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?	○	○

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")	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin changes thickening or dimpling	○	○
Excretions or changes of the nipple	○	○

	Yes	No
2. Are any of the above symptoms cycle related?	○	○
3. Are you still having your periods?	○	○

If yes, date of last period______________

	Yes	No
4. Have you had a surgical hysterectomy?	○	○

If yes, date_________________________ ○ Complete ○ Partial

Reason for hysterectomy?

○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

	Yes	No
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__________________________________

	Yes	No
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

	Yes	No
8. Have you had any cosmetic breast surgery or implants?	○	○

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:____

	Yes	No
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_________________

	Yes	No
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 __________________

	Yes	No
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?____________

	Yes	No
15. Have you ever been diagnosed with diabetes?	○	○

When__________________ List diabetes medication____________________________

16. Total mammograms_____

	Yes	No
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? __________

	Yes	No
20. Have you had breast ultrasound?	○	○

If yes…Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____

	Yes	No
21. Have you had breast MRI?	○	○

If yes…Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____

NOTES:

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	○	○
List disease ________________ Date of Diagnoses ______________________		
Lung disease?	○	○
List disease ________________ Date of Diagnoses ______________________		
Upper spine disorders?	○	○
List type of disorder __________ Date Diagnosed ________________________		
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
Details/Location ____		
4. Have you ever had surgery to your:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
List type of surgery and date ____		
5. Do you have asthma or shortness of breath?	○	○
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 any other digestive problems?	○	○	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	○	○
Stomach?	○	○	Spleen(Upper Left) ?	○	○
Below R Breast?	○	○	Liver(Upper Right) ?	○	○
Below L Breast?	○	○	Kidneys ?	○	○
Abdomen?	○	○	Intestines ?	○	○
Lower Back?	○	○	Abdomen ?	○	○
Pelvic Region?	○	○	Lower Back?	○	○
			Pelvic Region?	○	○

Have you consumed alcohol in the past 24 hours? ○ ○

*List abdomen & Lower back surgery or disease information.
*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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