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

Thermal Imaging services

Confidential Questionnaire

Men'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? If yes, ○ once a month or less ○ **more** than once a month	○	○
2. Do you have allergies? Food _____ Environmental_____	○	○
3. Do you have TMJ or does your jaw click?	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder? Type_____	○	○
6. Do you have neck pain?	○	○
7. Do you have upper back pain?	○	○
8. Do you have a history of carotid artery disease?	○	○
9. Do you have a family history of stroke?	○	○
10. Do you currently suffer with sinus problems?	○	○
11. Do you have history of dental problems? Root canals ____ Gum disease ____ Implants ____ Non-replaced extractions ____ Dentures ____	○	○
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?

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
Heart disease?	○	○
Lung disease?	○	○
Upper spine disorders?	○	○
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
4. Have you ever had surgery to your:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
5. Do you have asthma or shortness of breath?	○	○
6. Do you currently smoke?	○	○
7. Have you smoked in the past 5 years?	○	○

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

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer with acid reflux or 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? ○ ○

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	LT	RT	2. Have you had Surgery to:	LT	RT
Leg?	☐	☐	Leg?	☐	☐
Sciatica?	☐	☐	Sciatica?	☐	☐
Buttocks/Hip?	☐	☐	Buttocks/Hip?	☐	☐
Knees?	☐	☐	Knees?	☐	☐
Ankles?	☐	☐	Ankles?	☐	☐
Feet?	☐	☐	Feet?	☐	☐

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

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?	☐	☐	Shoulder?	☐	☐
Elbow?	☐	☐	Elbow?	☐	☐
Arm?	☐	☐	Arm?	☐	☐
Hands?	☐	☐	Hands?	☐	☐

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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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)

Thermal Imaging Services

Release of Client Information and Authorization.

By signing this document, I am authorizing Thermal Imaging Services to communicate my Physician's Insight Thermography Report to either my home address, another address listed below, or through Sendinc, an encrypted secure services, to my email listed below. I understand that any information on file will not be released to any outside 3rd party without my prior written permission.

Please indicate form of delivery you prefer when your report is ready

(*Please Check Only One*):

- ☐ Email
- ☐ Mail

Mail/Email Address:_____

Referring Doctor Only:

As a courtesy to you we send **one (1)** copy at no charge to the doctor who **referred you**.

- ☐ I would like my referring doctor to have a copy of the report

Mail/Email Address: _____

Additional Mailed ($10 charge per doctor): _____

_____

Disclaimer: Thermal Imaging Service is not responsible for non-delivery due to incorrect information given.

_____ I would like to join your email List: _____

Client Printed Name **Initials**

_____ _____

Client Signature or Responsible Party **Date**

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