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

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	○	○

	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

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 estrogen 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:____/____ (mth / year) Left _____ Right_____ Results: Negative____ Positive ____
21. Have you had breast MRI? ○ ○
    If yes…Date:____/____ (mth / year) 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______________

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
____
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.

____
Client Printed Name

I would like to join your email List: _______
Initials

____
Client Signature or Responsible Party

____
Date

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