Breast Health History

Thermography Clinic
#5, 9353 – 50 Street
Edmonton, Alberta T6E 1W9

Name________________________________ Birth Date________________ Today's Date ___________________

Address______________________________ City_____________________ Postal Code ___________________

Phone Number Home___________________ Cellular__________________ Work___________________________

E-Mail Address____

Referring Physician____

Is there a specific reason or concern for this 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	○	○

2. Are any of the above symptoms cycle related? ○ ○

3. Are you still having your periods? ○ ○
   If yes, date of last period______________________________

4. Have you had a surgical hysterectomy? ○ ○
   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? ○ ○
   If yes, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter
   Age diagnosed __________ Result of Treatment__________________________________

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

	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

11. Have you had pharmaceutical hormone replacement therapy (HRT)? ○ ○

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

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? ○ ○

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 ____

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

Thermography Clinic
#5, 9353 – 50 Street
Edmonton, Alberta T6E 1W9

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_________________