

Thermal Imaging of Morton

112 E Queenwood; Morton, IL 61550

Patient Intake Form

Name _____ DOB _____

Age ____ Gender ____ E-mail _____

Occupation _____

Street _____

City, State, Zip _____

Phone (Home) _____ (Work) _____ (Cell) _____

Reason for today's visit: _____

Current Symptoms: _____

Current Treatment: _____

Previous illnesses: _____

Have you ever had a Mammogram? Yes No If yes, when was the last one? _____

Have you ever had an abnormal Mammogram? Yes No If yes, list any follow-up testing procedures

Previous Surgeries/Dates: _____

Skin Lesions or Physical Abnormalities _____

Injuries/Dates: _____

Current Medication(s): _____

Dental History: (abscesses, implants, etc) _____

Do you want your report sent to your Health Care Provider? (circle one) Yes No

Provider's name and address: _____

Would you like Dr. Ehling to review your report? (circle one) Yes No

This information is confidential. All information is correct to my knowledge.

Signed: _____ Date: _____

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For office use only:

Patient ID# _____

Report Ref # _____ BR ROI HB FB

Referred by _____

Scans sent _____ Called _____

Pt rpt sent _____ HCP rpt sent _____

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Breast Questionnaire

Name: _____ DOB: _____

1. Do you have any close relative who has had breast cancer? Yes No
2. Have you ever been diagnosed with breast cancer? Yes No
3. Have you ever been diagnosed with any other breast disease (fibrocystic)? Yes No
4. Have you had any biopsies or surgeries to your breasts? Yes No
5. Have you had any breast cosmetic surgery or implants? Yes No
6. Have you had a mammogram in the past 12 months? Yes No
7. Have you had a mammogram in the past 5 years? Yes No
8. Have you had abnormal results from any breast testing? Yes No
9. Have you ever taken a contraceptive pill for more than 1 year? Yes No
10. Have you suffered with cancer of the womb? Yes No
11. Have you had pharmaceutical hormone replacement therapy? Yes No
12. Do you have an annual physical examination by the doctor? Yes No
13. Do you perform a monthly breast self exam? Yes No
14. Are you pregnant? Yes No
15. Are you breast feeding? Yes No
16. Have you breast fed in the past 3 months? Yes No
17. How many mammograms have you had in total? _____
18. What was your age when you had your first mammogram? _____
19. How many births have you had? _____ Your age at birth of first child: _____
20. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____
21. Do you smoke? Yes__ No __ Never __ Not in last 12 months __ Not in last 5 years__

Have you recently had any of these breast symptoms:

	Right Breast	Left Breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

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Patient Review of Body Systems

Name: _____ Date: _____

Constitutional

- ___ Fevers/Chills/Sweats
- ___ Unexplained weight loss/gain
- ___ Fatigue/weakness
- ___ Excessive thirst or urination

Musculo-Skeletal

- ___ Muscle/Joint Pain

Ears/Nose/Throat

- ___ Difficulty hearing/ringing
- ___ Hay Fever/Allergies

Cardiovascular

- ___ Chest Pain/Discomfort
- ___ Leg Pain w/Exercise
- ___ Palpitations

Other (please specify)

Dental

- ___ Extractions
- ___ Crowns
- ___ Root Canal
- ___ Gum Disease
- ___ Fillings
- ___ Other

Respiratory

- ___ Cough/Wheeze
- ___ Difficulty Breathing

Gastrointestinal

- ___ Heartburn/Reflux
- ___ Nausea/Vomiting/Diarrhea
- ___ Large bowel dysfunction
- ___ Abdominal Pain

Skin

- ___ Rash or Mole

Neurological

- ___ Numbness
- ___ Headaches

Organ Dysfunction

Blood/Lymphatic

- ___ Unexplained Lumps
- ___ Easy Bruising

General Medical History: Past and Current medical problems (please include dates)

- | | | |
|------------------------------|-------------------------|-----------------------|
| ___ Heart Disease: (specify) | ___ High Blood Pressure | ___ High Cholesterol |
| ___ Diabetes | ___ Thyroid Problem | ___ Kidney Disease |
| ___ Asthma/Lung Disease | ___ Chemical Exposure | ___ Cancer: (specify) |
| ___ Accidents | ___ Injuries | _____ |
| ___ Other: (specify) | | _____ |

Family History: Please indicate the current status of your immediate family members

(Mother, Father, Sibling, Grandparent, Aunt, Uncle)

- | | | |
|--------------------------|-------------------------|--------------|
| ___ High Cholesterol | ___ High Blood Pressure | ___ Diabetes |
| ___ Heart Disease | ___ Stroke | |
| ___ Bleeding or Clotting | ___ Genetic Disorders | |
| ___ Asthma/COPD | ___ Other | |
| ___ Cancer: type _____ | | |

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Pain Chart

Name: _____ Date _____

Please use the symbols below to indicate areas of:

Main Pain ●

Secondary Pain ○

Numbness // // // //

Pins and needles:

Skin lesions / scarring ↗

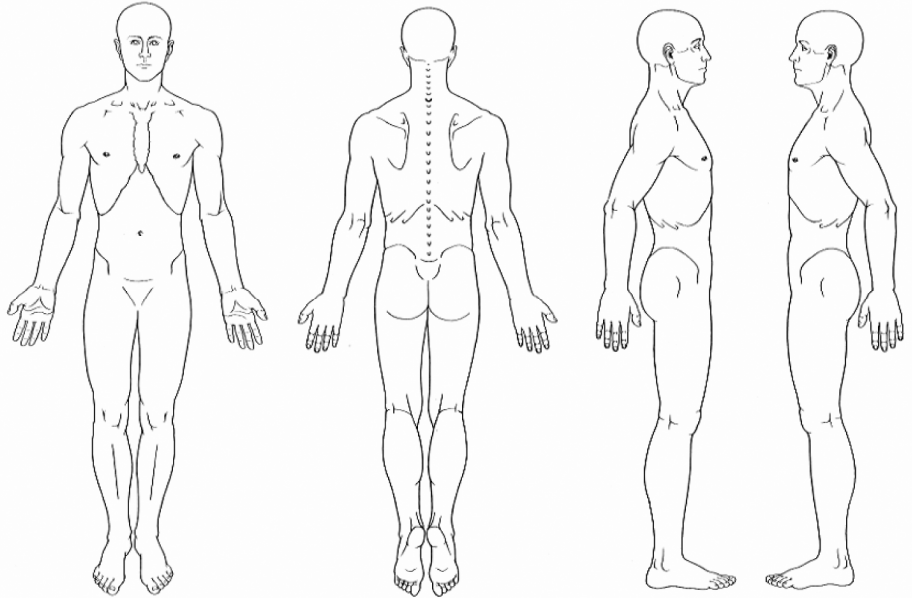
Do you know what triggered the pain?

Does anything relieve it?

Does anything aggravate it?

Has it changed since it began?

Have you had any treatment?



Patient Disclosure

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition, but will be an analysis of the Images with respect only to the thermographic findings of the areas discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature _____