Thermal Imaging of Morton

112 E Queenwood; Morton, IL 61550

Patient Intake Form

For office use only:

Patient ID# _____

Report Ref # _____ BR ROI HB FB

Referred by _____

Scans sent_____Called _____

Pt rpt sent_____HCP rpt sent _____

Name _____DOB_____

Age ___ Gender___E-mail_____

Occupation _____

Street_____

City, State, Zip_____

Phone (H) _____ (W) _____(C) _____

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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Breast Questionnaire

Name:_____ Date:_____

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	❑	❑
Tenderness	❑	❑
Lumps	❑	❑
Change in breast size	❑	❑
Areas of skin thickening or dimpling	❑	❑
Secretions of the nipple	❑	❑

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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)

___Diabetes

___Asthma/Lung Disease

___Injuries

___High Blood Pressure

___Thyroid Problem

___Chemical Exposure

___Cancer: (specify)_____

___High Cholesterol

___Kidney Disease

___Accidents

___Other: (specify) _____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___High Cholesterol

___Heart Disease

___Genetic Disorders

___Cancer: type _____

___High Blood Pressure

___Stroke

___Asthma/COPD

___Diabetes

___Bleeding or Clotting

___Other

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_____