

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 (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: _____

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 (for women only)

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)

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease: (specify) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma/Lung Disease | <input type="checkbox"/> Chemical Exposure | <input type="checkbox"/> Cancer: (specify) |
| <input type="checkbox"/> Accidents | <input type="checkbox"/> Injuries | _____ |
| <input type="checkbox"/> Other: (specify) | | _____ |

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

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Bleeding or Clotting | <input type="checkbox"/> Genetic Disorders | |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Other | |
| <input type="checkbox"/> 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 ↗

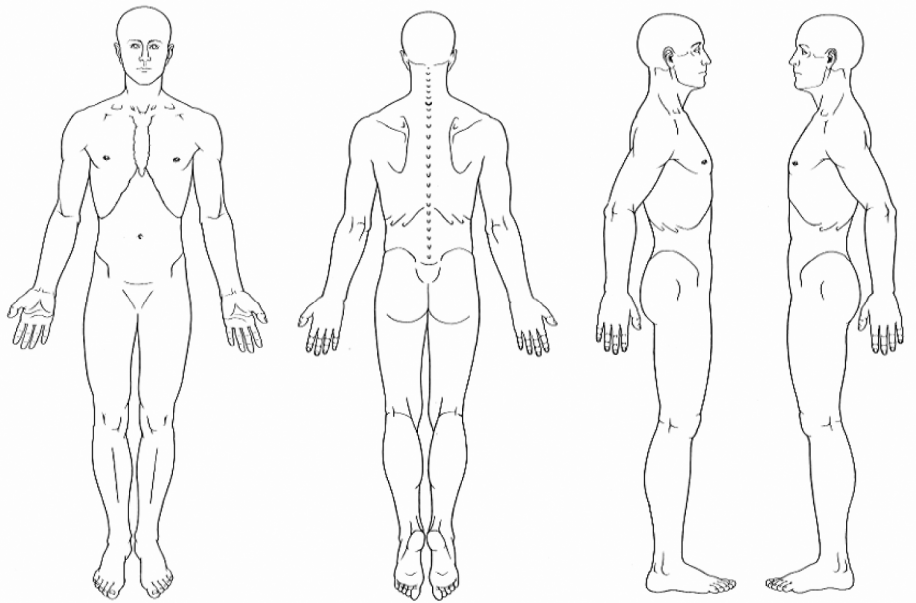
Do you know what triggered the pain?

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 _____