

# Confidential Questionnaire

## *Women's Comprehensive Full Body*

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number (home) \_\_\_\_\_ (cellular) \_\_\_\_\_ (work) \_\_\_\_\_  
 E-Mail Address \_\_\_\_\_ Referring Physician \_\_\_\_\_

*All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.*

**Yes    No**

### ***Head & Neck***

- |  |                       |                       |
|--|-----------------------|-----------------------|
| 1. Do you suffer with headaches?<br>If yes, <input type="radio"/> once a month or less <input type="radio"/> more than once a month                    | <input type="radio"/> | <input type="radio"/> |
| 2. Do you have known allergies?    Food _____ Environmental _____  | <input type="radio"/> | <input type="radio"/> |
| 3. Do you have TMJ or does your jaw click?   | <input type="radio"/> | <input type="radio"/> |
| 4. Do you currently have a cold?   | <input type="radio"/> | <input type="radio"/> |
| 5. Are you being treated for a thyroid disorder?    Type _____   | <input type="radio"/> | <input type="radio"/> |
| 6. Do you have neck pain?  | <input type="radio"/> | <input type="radio"/> |
| 7. Do you have upper back pain?  | <input type="radio"/> | <input type="radio"/> |
| 8. Do you have a known history of carotid artery disease?  | <input type="radio"/> | <input type="radio"/> |
| 9. Do you have a family history of stroke?   | <input type="radio"/> | <input type="radio"/> |
| 10. Do you currently suffer with sinus problems?   | <input type="radio"/> | <input type="radio"/> |
| 11. Do you have history of dental problems?<br>Root canals _____ Gum disease _____ Implants _____<br><br>Non-replaced extractions _____ Dentures _____ | <input type="radio"/> | <input type="radio"/> |
| 12. Have you had dental cleaning in the past 7 days?   | <input type="radio"/> | <input type="radio"/> |

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

# Breast

Is there a specific reason or concern for this breast exam?

- |   | Yes                   | No                    |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
|---|-----------------------|-----------------------|----|-----------------|-----------------------|-----------------------|-------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|--|-----------------------|-----------------------|--------------------------|-----------------------|-----------------------|--|--|
| 1. Have you recently had any of these breast symptoms?  | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%; text-align: center;">LT</th> <th style="width: 20%; text-align: center;">RT</th> </tr> </thead> <tbody> <tr> <td>Pain/Tenderness</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Lumps</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Change in breast size</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Areas of skin changes thickening or dimpling</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Excretions of the nipple</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </tbody> </table> |                       | LT                    | RT | Pain/Tenderness | <input type="radio"/> | <input type="radio"/> | Lumps | <input type="radio"/> | <input type="radio"/> | Change in breast size | <input type="radio"/> | <input type="radio"/> | Areas of skin changes thickening or dimpling | <input type="radio"/> | <input type="radio"/> | Excretions of the nipple | <input type="radio"/> | <input type="radio"/> |  |  |
|   | LT                    | RT                    |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| Pain/Tenderness   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| Lumps   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| Change in breast size   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| Areas of skin changes thickening or dimpling  | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| Excretions of the nipple  | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 2. Are any of the above symptoms cycle related?   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 3. Are you still having periods?<br>If yes, date of last period _____   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 4. Have you had a surgical hysterectomy?<br>If yes, date _____ <input type="radio"/> Complete <input type="radio"/> Partial<br>Reason for hysterectomy:<br><input type="radio"/> Excess bleeding <input type="radio"/> Endometriosis <input type="radio"/> Fibroid cysts <input type="radio"/> Cancer <input type="radio"/> Other _____   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 5. Has anyone in your family ever been treated for breast cancer?<br>If yes, <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter<br>Age diagnosed _____    Result of Treatment _____   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 6. Have you ever been diagnosed with breast cancer?<br>If yes, date _____<br>Cancer type <input type="radio"/> Local <input type="radio"/> Metastatic <input type="radio"/> Lymph node involvement<br>Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple<br>Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple<br>Treatment <input type="radio"/> Surgery <input type="radio"/> Chemo <input type="radio"/> Radiation <input type="radio"/> None   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 7. Have you ever been diagnosed with any other breast disease?<br>If yes, <input type="radio"/> Cysts/fibrocystic <input type="radio"/> Fibro Adenoma <input type="radio"/> Mastitis/inflammatory breast disease  | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |
| 8. Have you had any cosmetic breast surgery or implants?<br>If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline<br>Experience <input type="radio"/> Problems <input type="radio"/> No problems   | <input type="radio"/> | <input type="radio"/> |    |                 |                       |                       |       |                       |                       |                       |                       |                       |  |                       |                       |                          |                       |                       |  |  |

- |  | Yes                   | No                    |
|--|-----------------------|-----------------------|
| 9. Have you ever had any biopsies or any other surgeries to your breasts?<br>If yes, date _____  | <input type="radio"/> | <input type="radio"/> |
| Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple   |                       |                       |
| Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple  |                       |                       |
| Results <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Calcifications   |                       |                       |
| 10. Have you ever taken contraceptive pills for more than one year?<br>If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years | <input type="radio"/> | <input type="radio"/> |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)?<br>If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years  | <input type="radio"/> | <input type="radio"/> |
| 12. Do you have an annual physical examination by a doctor?  | <input type="radio"/> | <input type="radio"/> |
| 13. Do you perform a monthly breast self exam?   | <input type="radio"/> | <input type="radio"/> |
| 14. Have you ever smoked?  | <input type="radio"/> | <input type="radio"/> |
| 15. Have you ever been diagnosed with diabetes?  | <input type="radio"/> | <input type="radio"/> |
| 16. Total Mammograms _____   |                       |                       |
| 17. Date of your last mammogram _____ Were you re-called?  | <input type="radio"/> | <input type="radio"/> |
| 18. Your age at your first mammogram? _____  |                       |                       |
| 19. Number of full term pregnancies? _____   |                       |                       |
| 20. Have you had breast ultrasound?<br>If yes...Date: ___/___/___ Left ___ Right ___ Results: Negative ___ Positive ___  | <input type="radio"/> | <input type="radio"/> |
| 21. Have you had breast MRI?<br>If yes...Date: ___/___/___ Left ___ Right ___ Results: Negative ___ Positive ___   | <input type="radio"/> | <input type="radio"/> |

## ***Chest, Heart & Lungs***

- |   | Yes                   | No                    |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with:              |                       |                       |
| Heart disease?                                | <input type="radio"/> | <input type="radio"/> |
| Lung disease?                                 | <input type="radio"/> | <input type="radio"/> |
| Upper spine disorders?                        | <input type="radio"/> | <input type="radio"/> |
| 2. Do you suffer with upper back pain?        | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain?             | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had surgery to your:         |                       |                       |
| Heart?  | <input type="radio"/> | <input type="radio"/> |
| Lungs?  | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back?                            | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |

6. Do you currently smoke? Yes No
7. Have you smoked in the past 5 years? Yes No

## *Abdomen & Lower Back*

	Yes	No		Yes	No
1. Do you suffer with acid reflux or other digestive problems?	<input type="radio"/>	<input type="radio"/>	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	<input type="radio"/>	<input type="radio"/>
Stomach?	<input type="radio"/>	<input type="radio"/>	Spleen(Upper Left) ?	<input type="radio"/>	<input type="radio"/>
Below R Breast?	<input type="radio"/>	<input type="radio"/>	Liver(Upper Right) ?	<input type="radio"/>	<input type="radio"/>
Below L Breast?	<input type="radio"/>	<input type="radio"/>	Kidneys ?	<input type="radio"/>	<input type="radio"/>
Abdomen?	<input type="radio"/>	<input type="radio"/>	Intestines ?	<input type="radio"/>	<input type="radio"/>
Lower Back?	<input type="radio"/>	<input type="radio"/>	Abdomen ?	<input type="radio"/>	<input type="radio"/>
Pelvic Region?	<input type="radio"/>	<input type="radio"/>	Lower Back?	<input type="radio"/>	<input type="radio"/>
			Pelvic Region?	<input type="radio"/>	<input type="radio"/>

Have you consumed alcohol in the past 24 hours?

## *Legs & Feet*

Check only if "Yes"

	LT	RT		LT	RT
1. Do you suffer pain in the:			2. Have you had Surgery to:		
Leg?	<input type="radio"/>	<input type="radio"/>	Leg?	<input type="radio"/>	<input type="radio"/>
Sciatica?	<input type="radio"/>	<input type="radio"/>	Sciatica?	<input type="radio"/>	<input type="radio"/>
Buttocks/Hip?	<input type="radio"/>	<input type="radio"/>	Buttocks/Hip?	<input type="radio"/>	<input type="radio"/>
Knees?	<input type="radio"/>	<input type="radio"/>	Knees?	<input type="radio"/>	<input type="radio"/>
Ankles?	<input type="radio"/>	<input type="radio"/>	Ankles?	<input type="radio"/>	<input type="radio"/>
Feet?	<input type="radio"/>	<input type="radio"/>	Feet?	<input type="radio"/>	<input type="radio"/>

## *Arms & Hands*

*(Check only if "yes")*

	LT	RT		LT	RT
1. Do you suffer with pain in the:			2. Have you had surgery to:		
Shoulder?	<input type="radio"/>	<input type="radio"/>	Shoulder?	<input type="radio"/>	<input type="radio"/>
Elbow?	<input type="radio"/>	<input type="radio"/>	Elbow?	<input type="radio"/>	<input type="radio"/>
Arm?	<input type="radio"/>	<input type="radio"/>	Arm?	<input type="radio"/>	<input type="radio"/>
Hands?	<input type="radio"/>	<input type="radio"/>	Hands?	<input type="radio"/>	<input type="radio"/>

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 \_\_\_\_\_

# **The Charlotte Thermography Center**

10550 Independence Pointe Parkway Ste. 100  
Matthews, NC 28105  
704-849-9393

## **Patient Pre-Scan Instructions:**

To achieve an accurate evaluation, you should avoid conditions that would cause artificial influences. Please fill out your patient history forms prior to your appointment and contact our office with any questions you might have that are not covered here.

1. Unless specifically instructed by your physician, you should wait at least three (3) months after any form of breast surgery (including biopsy), the completion of chemotherapy or radiation before your study.
2. You should avoid any natural or artificial tanning of your chest for three (3) days prior to your study.
3. You must avoid any vigorous physical stimulation, examination or compression of the breasts (self or clinical examination, ultrasound or mammogram) for at least three (3) days prior to your study.
4. You must not have had significant fevers (102 or more) within thirty-six (36) hours of your study or have any level of fever on the day of your study.
5. You should refrain from a sauna, steam-room or hot/cold packs in contact with your breasts for at least twenty-four (24) hours prior to your study.
6. There should be no new bruising, rashes or skin irritation on your breasts or underarms on the day of your study.
7. You should not use any skin creams, lotions, deodorants or powders that may cause inflammation on your breasts or underarms on the day of your study.
8. With your physician's permission, please do not use the following medications for twelve (12) hours prior to your study: niacin or niacin patch (500 milligrams or more), nitroglycerin or any migraine medication.
9. You should avoid any tobacco use or caffeinated coffee or tea consumption for two (2) hours prior to your study.
10. You should avoid vigorous exercise, bathing or showering for one (1) hour prior to your study.
11. If you are breast-feeding, please empty your breasts 30-60 minutes prior to your study.
12. Please remove all jewelry.
13. Long hair should be worn up or pulled back off your shoulders prior to being scanned.
14. For your comfort, we recommend you wear a blouse and pants or skirt to your study.
15. For a breast scan, please do not wear a bra to exam but you can bring one for after the exam.

THE CHARLOTTE THERMOGRAPHY CENTER

Notice of Privacy Practices

I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

With whom may we discuss your care:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

How should we contact you?

Phone 1<sup>st</sup> choice \_\_\_\_\_

2<sup>ND</sup> choice \_\_\_\_\_

e-mail \_\_\_\_\_

If you prefer to be contacted by phone, may we leave a message -

on the voice mail? Yes No

with the person answering the phone? Yes No

# The Balanced Body Center

## Authorization to use or Disclose Protected health Information

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

As required by the Privacy Regulations, The Balanced Body Center may not use or disclose your protected health information except as provided in our Notify of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), and business associates of this office:

### Physicians Insight MD's Clinical Interpretation

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Receive a copy of this authorization.

\_\_\_\_\_  
Signature of Patient or Patient's Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Representative-Balanced Body Center

\_\_\_\_\_  
Date



**THE CHARLOTTE THERMOGRAPHY CENTER**

**Attention: Patients that intend to use your personal health insurance to pay for any portion of care in this office.**

We are not contracted with any insurance companies for thermography services. We ask that you pay at time of service, and we will provide a receipt that you may submit to your insurance company.

I understand that I am responsible for the cost of my thermography.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date