Thermography Center
OF FAIRFAX

BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONAIRE

NAME:_____ **BIRTHDATE:**_____

ADDRESS:_____ **CITY:**_____ **ZIP:**_____

EMAIL:_____ **PHONE:**_____ **DOCTOR:**_____

All information will remain confidential and will only be divulged to the reporting thermologist and any specified practitioner.

	YES	NO
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
5. Have you had any breast cosmetic surgery or implants?	☐	☐
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you suffered with cancer of the womb?	☐	☐
11. Have you had pharmaceutical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

14. Had vaccination in the past 4 weeks? (circle one) **Right Arm** **Left Arm** **None**
15. How many mammograms have you had in total? _____
16. What was your age when you had your first mammogram? _____
17. How many births have you had? _____ Your age at birth of first child? _____
18. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____
19. Do you smoke? ____ Yes ____ 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	____	____

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 discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature_____ **Date:**_____