

New England Clinical Thermography

Breast Thermography Confidential Questionnaire

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

Name: _____ MI: _____ Birth date: _____
Address: _____ City _____ Zip _____
Phone: _____ Doctor: _____

- | | Yes | No |
|---|-----|-----|
| 1. Do you have any close relative who has had breast cancer?
If yes, which relative? _____ | ___ | ___ |
| 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? | ___ | ___ |
| <u>If you answer yes to any of questions 2, 3 or 4 you must complete page 2!!!</u> | | |
| 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. How many mammograms have you had in total? _____ | | |
| 15. What was your age when you had your first mammogram? _____ | | |
| 16. How many births have you had? _____ Your age at birth of first child: _____ | | |
| 17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____ | | |
| 18. Do you smoke? (Circle) Yes Never Not in last 12 months Not in last 5 years | | |
| Have you <u>recently</u> had any of these breast symptoms: | | |
| Pain | ___ | ___ |
| Tenderness | ___ | ___ |
| Lumps | ___ | ___ |
| Change in breast size | ___ | ___ |
| Areas of skin thickening or dimpling | ___ | ___ |
| Secretions of the nipple | ___ | ___ |

If you have any of the above symptoms, see page 2

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 discussed in the Report.

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

Signature _____ Today's date _____

Extended Breast Questionnaire

Patient Name: _____ Date: _____

Diagnosed with breast cancer:

Cancer type: _____ Local _____ Lymph node involvement _____

When diagnosed: Month _____ Year _____

Where:	left breast	right breast
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

Treatment: Surgery _____ Chemo _____ Radiation _____ Other _____ None _____

Diagnosed with other breast disease:

Disease type: Fibrocystic _____ Cystic _____ Mastitis _____ Abscess _____ Other _____

(please report other types of disease in the history)

Breast biopsies or surgery: (indicate which)

Where:	left breast	right breast
Upper outer	_____	_____
Upper Inner	_____	_____
Lower Outer	_____	_____
Lower Inner	_____	_____
Nipple Region	_____	_____

Dates of biopsies/surgery _____

Result of biopsies/surgery _____

Recent breast symptoms: Are they menstrual cycle related? Yes No (circle)

If not, how recently did they develop? _____

Any other comments on breast symptoms: _____

The purpose of this form is for the patient to authorize sending New England Clinical Thermography to send images to the interpretation service (EMI). They are a separate company and we cannot send your images and the accompanying medical history without your permission.

Authorization to Use or Disclose Protected Health Information to The EMI Interpretation Service

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, NECT may not use or disclose your protected health information except as provided in our Notice 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), or business associates of this office:

EMI, Electronic Medical Interpretations

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

For the specific purpose of (describe in detail) - **Interpretation of thermal images**

Effective dates for this authorization: ____/____/____ through ____/____/____

This authorization will expire at the end of the above period. **(Leave dates blank if you would like this authorization to be on-going.)**

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. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date

Patient Education - Breast Screening with Digital Infrared Thermal Imaging (Thermography).

Purpose of test: For early detection of abnormal changes in the breasts requiring further diagnostic testing.

Patient preparation:

Do not smoke for 2 hours before the test.

Do not workout prior to imaging on the day of the test.

Do not use lotions or powder on your breasts or surrounding areas on the day of test. Note, this includes no use of underarm deodorant/antiperspirant.

If you must use, apply as little as possible and only directly in the armpit itself.

We will be imaging the upper back and neck so hair must be up off of the neck.

Please pin up or headband in advance or a headband will be provided when you come for imaging.

Avoid sun exposure on day of test – this includes tanning equipment and existing sunburns.

Diet - No changes necessary

Medicines - No changes necessary

Read and completely fill out forms provided and bring with you on test day.

The Test

Enter imaging room, disrobe to waist, put on standard gown.

Allow time for body to acclimate to room temperature.

Thermographer will review paperwork for any issues.

5 Standard breast images are then taken, plus an extra front and back image.

Quick review of images by Certified Thermographer.

Dress.

Closing discussion to review any questions.

Disrobing - Remove all upper body clothing and jewelry. Put on surgical gown supplied.

Inform your Thermographer if you have had any recent skin lesions on your breast; the inflammation can cause a false positive result.

How the test will feel:

The room air may feel cool on your breasts as they adjust to room temperature before scanning. Examining room temperatures are comfortable when you disrobe for the examination.

Any apprehension about the sophisticated thermography equipment is soon dispelled. The procedure is totally non- invasive, the camera does not emit radiation of any kind.

Time before test results available:

Time before results are reported to the doctor or patient varies from a few hours to a few days.

Frequently asked questions:

Who performs test? Female Imaging Technician

Any risks or side effects? None. Procedure non-invasive, non-contact, no radiation.

How long does it take ? Appointments are 30 minutes.

You are welcome to bring a companion or partner to be present at the examination

While participation in a DITI early detection program can increase your chance of detecting and monitoring breast disease, as with all other tests, it is still not a 100% guarantee of detection.

New England Clinical Thermography Incorporated

Patient Information Sheet

Last Name: _____ First: _____ MI: _____

DOB _____

Previous Illnesses: _____

Current Health Problems: _____

Medications: _____

Other Treatment: _____

Current Doctor: _____

Address: _____

Phone: _____

How did you learn of imaging at this location? _____

This information is confidential.

All Information is correct to my knowledge.

Signed: _____ Date: _____