Name: ______________________________ Mrs/Miss/Ms ID NO: ____________

Address: ____

Town: ______________________________________ Postcode: ____________

DOB: ____________________ GP: ____________________

Phone No: ____________________ Mobile No: ______________________

Email Add: ______________________________

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.

Breast Thermography Confidential Questionnaire

1. Have you had any close relative who has had breast cancer? Y / N
2. Have you ever been diagnosed with breast cancer? [if Yes P.T.O] Y / N
3. Have you ever been diagnosed with any other breast disease [fibrocystic]? Y / N
4. Have you had any biopsies or surgeries to your breasts? Y / N
5. Have you had any breast cosmetic surgery or implants? Y / N
6. Have you had a mammogram in the past 12 months? Y / N
7. Have you had a mammogram in the past 5 years? Y / N
8. Have you had abnormal results from any breast testing? Y / N
9. Have you ever taken a contraceptive pill for more than a year? Y / N
10. Have you suffered with cancer of the womb? Y / N
11. Have you had pharmaceutical hormone replacement therapy? Y / N
12. Do you have an annual physical examination by a doctor? Y / N
13. Do you perform a monthly breast self examination? Y / N
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? ______ Age at birth of first child: ______
17. Did your periods start before the age of 12? _____ Did your periods finish after the age of 50 ______
18. 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	Y / N	Y / N
Tenderness	Y / N	Y / N
Lumps	Y / N	Y / N
Change in breast size	Y / N	Y / N
Areas of skin thickening or dimpling	Y / N	Y / N
Secretions of the nipple	Y / N	Y / N

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for the 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: ________________