THERMOGRAPHIC HEALTH ADVANTAGE, LLC

Julie Connor, Certified Level 3 Clinical Thermographer

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www.ThermographicHealthAdvantage.com

First Name:

Last Name:

Date of Birth:

Address:

City:

State/Province:

Zip/Postal Code:

Email Address:

Cell Phone:

Home Phone:

What is your current age?

Occupation:

Have you received the Covid vaccine?
It is recommended that all thermography clients wait at least 4 weeks after their last vaccine before scheduling an appointment.

Date of last vaccine or booster:
Vaccine administered in:
Left arm
Right Arm
Not Vaccinated

Name of Physician or practitioner who referred you:

Would you like your report and images emailed to your physician or practitioner?

Please provide the email address of your physician or practitioner to send your thermography images and reports to:

Patient Health History:

Current health concerns or symptoms:

Previous surgeries:

Do you have frequent or chronic pain, or discomfort in your body?
Please indicate how many weeks, months or years this has been happening. Describe the pain or discomfort, its frequency, intensity, location, and if anything triggers it. Write N/A if none

Findings or diagnosis from a prior health screening:
If you have a cancer history please bring a copy of all reports from biopsies, surgeries, mammograms, sonograms, MRI and CT scans to your appointment. Or email a copy to Julie at ThermographicHealth@gmail.com

Have you ever been diagnosed with any or had any of the following conditions?

Please circle all that apply

Allergies	Anemia	Arthritis	Asthma
Blood Disorder	Carpal Tunnel	Chronic Sinusitis or Rhinitis	COPD
Crohn's Disease	Diabetes	Diverticulitis	Fibromyalgia or Chronic Fatigue
GERD	Headache or Migraine	Heart Disease	Herniated Disc
High Blood Pressure	High Cholesterol	IBS or IBD	Immune Dysfunction
Liver Disease	Lung Disease	Multiple Sclerosis	Neuropathy
Numbness or Tingling in Arms	Numbness or Tingling in Legs	Osteoarthritis	RSD Reflex Sympathetic Dystrophy
Spinal Stenosis	Stroke	TMJ	Ulcerative Colitis

Please provide any additional information regarding the above mentioned conditions:

Are you receiving any current Treatments: Chiropractic, Massage, Physical Therapy, Homeopathy, Naturopath, or Acupuncture?

Current medications: Name of prescription, dosage and frequency:

Have you had any dental procedures or a dental cleaning in the last week?
It is recommended that you wait one week after a dental cleaning and longer if you've had any recent dental surgery (implant, extraction, root canal)

Dental Surgery History - Extractions, root canal, implants, or other:

Do you have any skin lesions, large birthmarks, scars, tattoos, history of skin cancers or other skin abnormalities?
Please indicate locations of each.

Are there any notable medical conditions of family members?

Have any of these relatives been diagnosed with breast cancer?
Mother
Sister
Maternal Aunt
Paternal Aunt
Maternal Grandmother
Paternal Grandmother
Maternal Cousin
Paternal Cousin

Have you ever been diagnosed with breast cancer? If yes, when?

Please circle if you have had any of the following breast diseases?

Fibrocystic Fibroadenoma Papilloma

Mastitis Cystic Calcifications

Have you ever had any biopsies or surgeries to breasts?

Date of last biopsy or breast surgery:

Have you ever had any breast cosmetic surgery or implants?
Dates and location of surgeries or biopsies:

Left Breast Upper Outer
Left Breast Upper Inner
Left Breast Lower Outer
Left Breast Lower Inner
Left Breast Nipple Area
Right Breast Nipple Area
Right Breast Upper Outer
Right Breast Upper Inner
Right Breast Lower Outer
Right Breast Lower Inner

Have you had a mammogram in the past 5 years?

Have you had a mammogram in the past 12 months?

Have you had more than 30 mammograms in your lifetime?

Date of last Mammogram:

Have you ever had any abnormal results from any breast screening? (Mammography, sonogram, MRI, CT scan)

What was the diagnosis or abnormal findings?

Please check if you have any of these breast symptoms:

Right breast tenderness
Left breast tenderness
Right breast lump
Left breast lump
Right breast change in size
Left breast change in size
Right breast areas of skin thickening or dimpling
Left breast areas of skin thickening or dimpling
Right breast secretions from the nipple
Left breast secretions from the nipple

Have you ever taken an oral contraceptive for more than 1 year?

Have you ever taken an oral contraceptive for more than 4 years?

Have you ever been diagnosed with ovarian, uterine, or cervical cancer?

If yes, please provide further information.

Have you ever taken pharmaceutical hormone replacement therapy?

Do you have an annual physical examination by a doctor?

Do you perform a monthly breast self exam?

Did your periods start before the age of 12?

Did your periods end after the age of 50?

Have you ever given birth to a child?

At what age did you give birth to your first child?

History of smoking:

Currently smoke	Not in the last five years	
Not in the last 10 years	Not in the last 20 + years	Never

Have you had chemotherapy or radiation treatment?

Date of last chemotherapy or radiation treatment:

Do you have dense breast tissue?

Is your menstrual cycle irregular?

Do you still have a menstrual cycle?
If no, when was your last period?

Do you experience cramping during menstrual cycle?

Do you observe heavy bleeding during menstrual cycle?

Do you experiencing breast pain and tenderness that comes and goes?

Do you have you had any breast lumps that come and go?

Do you have low libido?

Do you experience hot flashes?

Have you ever been diagnosed with endometriosis?

Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)?

Have you ever been treated for infertility? If yes, when?

Do you have any swelling in the neck or trouble swallowing?

Have you ever been diagnosed with any of these thyroid disorders?
Hashimoto's
Graves Disease
Hypothyroidism
Hyperthyroidism
None

Do you regularly experience fatigue?

Have you experienced recent hair loss?

Does Thermographic Health have your permission to use texting and email as a means of communication?

Texting would primarily be used for appointment reminders, to clarify information regarding your health history, or additional information concerning your thermography appointment.
You can update and change your preferences at any time via email or text.

Please circle your preferences.

Yes, I give permission to use texting as a means of communication with Thermographic Health Advantage.

Yes, I give permission to receive copies of my thermography reports and images via email, and as a means of communication with Thermographic Health Advantage.

Yes, I would like to receive automated email reminders for my follow-up and annual thermogram studies.

No, I do not give permission to use texting as a means of communication with Thermographic Health Advantage.

No, I do not give permission for Thermographic Health Advantage to send copies of my report and images via email, or as a means of communication.

No, I do not wish to receive automated reminders for follow-up and annual thermography studies.

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 Thermography 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. Breast thermography screening is an adjunctive test to mammography, ultrasound, and MRI and is a specialized physiological test designed to detect angiogenesis, hyperthermia from nitric oxide, estrogen dominance, lymph abnormality, and inflammatory processes including inflammatory breast disease, all of which cannot be detected with structural tests.

☐ By checking this box, I certify that I have read and understand the statements above and consent to the examination and that the above information is correct to my knowledge.

Print Full Name_____

Signature _____

Date _____