HealthWalk™
Your Path to Vibrant Health™

Digital Infrared Thermal Imaging

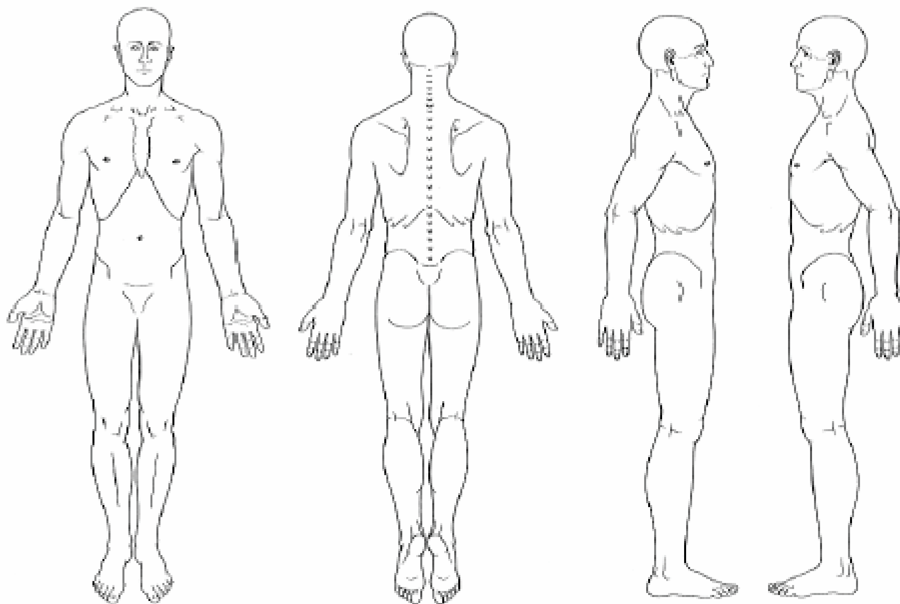
Questionnaire and Patient Information Sheet

Name________________________________ **Birth Date** ____________________
Phone ________________ Cell ________________ Email ______________________
Referring Practitioner ___________________________

Scan Type: ___Breast/Lymph (1 ROI) ___Visceral (1 ROI) ___Cranial/Jaw (1ROI)
___Upper/Lower (2 ROI) ___Upper/Lower +Breast (3 ROI) ___Full Body +Breast (4 ROI)

Please show areas of:

* Main Pain ○ Secondary Pain //// Numbness .... Pins & Needles **X** Skin Lesions & Scars



Do you know what triggered the pain? ______________________________________
Does anything relieve it? ____
Has it changed since it began? ____
Have you had any treatment? ____

History: Fractures / Injuries / Surgery _________________________________
____
____
____

All information given on the questionnaire will remain strictly confidential and will only be divulged to Electronic Medical Interpretation (reporting thermologist) and practitioner(s) that you specify.

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 of the areas 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 ______________________

Digital Infrared Thermal Imaging
Breast Thermography Questionnaire

Name________________________________ **Birth Date** ______________________

		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. How many mammograms have you had in total? _______ Age at first mammogram: _______

15. How many births have you had? _______ Your age at birth of first child: _______

16. Did your periods start before the age of 12? _______ Or finish after the age of 50? _______

17. Do you smoke? Yes ☐ Never ☐ Not in the last 12 months ☐ Not in the 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	☐	☐

Diagnosed with breast cancer:

Cancer type: Metastatic ☐ Local ☐ Lymph node involvement ☐
When diagnosed: Month _____ Year _____
Where (left breast) UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐
Where (right breast) UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐
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:

Where (left breast) UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐
Where (right breast) UO ☐ UI ☐ LO ☐ LI ☐ Nipple ☐

Signature ______________________________ Date______________________________