Name: **Birthdate:**

Address: **City** **Zip**

Email: **Phone:**

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

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. 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. Did your periods start before the age of 12?	☐	☐
15. Or finish after the age of 50?	☐	☐

How many mammograms have you had in total? _____

What was your age when you had your first mammogram? _____

How many births have you had?___

Your age at birth of first child:___

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	☐	☐

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 _____

Patient Information Sheet.

Name …… D.O.B. ……

Address ……City……Zip……

Phone…… Email ……

Previous Illnesses.

Previous Surgery.

Current Health Problems.

Medication. ……

Other Treatment. ……

Current Doctor. ……

This information is confidential. All information is correct to my knowledge.

Signed …… Date ……

_____OFFICE USE_____

Clinic_____ Scan performed:_____ Last scan date_____

Amount_____ Paid by_____ Deposit_____

_____

Authorization to Use or Disclose Protected Health Information

Client Name:_____DOB:_____

Address_____City,State,Zip_____

Phone: _____ Email:_____

As required by the Privacy Regulations, *The Longevity Center LLC* 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 Client Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Client Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of **Interpretation of said images.**

I request my Report and Images be sent to me:

_____Via email on a secure, password protected PDF Report (NO CHARGE)

_____Via Writable Disc on a PDF by US Mail ($5.00 charge applies)

_____Via Paper copy by US Mail ($5.00 charge applies)

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. Inspect a copy of Client Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.

I also understand that if I do not sign this document, I do not authorize The Longevity Center to use or disclose protected Client health information.

Signed_____ Date_____