

Patient Information Sheet

Name: _____ Age: _____ D.O.B.: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Previous Illnesses/Surgeries:

Any skin lesions or abnormalities in area you are being scanned? Yes No

If Yes, Where? _____

Current Health Issues/Concerns:

OBGYN History: _____

Last Mammogram or Ultrasound: _____

Medications: _____

Current Treatments: _____

Current Doctor. _____ Referred? Yes No

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

Signed _____ Date : _____

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? If yes, who? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Ever been diagnosed w/ breast cancer? If yes, where? Date: Treatments: | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Ever been diagnosed with any other breast disease (fibrocystic mastitis)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Have you had any biopsies or surgeries to your breasts? If yes, where? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Have you had any breast cosmetic surgery or implants? If yes, what year? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Have you had a mammogram in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Have you had a mammogram in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Have you had abnormal results from any breast testing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Taken a contraceptive pill more than 1 year? If yes, how many yrs? _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Have you suffered with cancer of the womb? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Taken pharmaceutical hormone replacement? If yes, how many yrs? _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| 12. Do you have an annual physical examination by a doctor? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 13. Do you perform a monthly breast self exam? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14. Did your periods start before the age of 12? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15. Or finish after the age of 50? | <input type="checkbox"/> | <input type="checkbox"/> | |

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	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

OFFICE USE ONLY

Clinic: _____ Scan performed: _____ Last scan date: _____

Amount: _____ Paid by: _____ Deposit: _____

Authorization to Use or Disclose Protected Health Information

Client Name: _____ Age: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone: _____ Email: _____

Last Mammogram: _____ Last Ultrasound: _____

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 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: _____