BREAST HISTORY

Date of Study: _____

Scan ID#: _____

Name: _____
Last First Middle

Address: _____
Number Street City State Zip Code

Phone: _____ **Date of Birth**: _____**Sex**: **M** ☐ **F** ☐ **Age**: _____ **Weight**: _____

Physicians Name: _____ MD DO NMD

Physician's Address: _____
Number Street City State Zip Code

1. Have you had a previous thermology study? Yes☐ No ☐
   Date:_____ Name of Clinic: _____

2. How many times have you been diagnosed with breast cancer? _____ Which side? Left☐ Right☐
   When was biopsy done? _____ What stage? 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ unknown☐
   What type? Ductal ☐ Lobular ☐ Inflammatory ☐ Paget's ☐ Phyllodes ☐ Don't recall ☐
   What surgery did you undergo? None ☐ Lumpectomy ☐ Mastectomy ☐
   Date of surgery: _____
   What treatment did you receive? None ☐ Radiation ☐ Chemotherapy ☐
   Date of your last treatment: _____
   Provide the type of reconstructive surgery you had: None ☐ DIEP ☐ Lat Dorsi flap ☐ SGAP ☐
   TRAM flap ☐ Autologous fat graft ☐ Implant ☐ Other _____
   Date of surgery: _____

3. How many times have you had non-cancer breast surgery? This includes cosmetic surgery (implants, reduction, lift), all non-cancerous biopsies, aspirations and any other cosmetic surgery.
   _____ Which side? Left ☐ Right ☐ Date of surgery (surgeries): _____
   _____ _____ _____ _____ _____
   Type of surgery: Aspirations ☐ Biopsy ☐ Implants ☐ Lift ☐ Reduction ☐ Other: _____

4. How many times have you had any abnormal results from breast testing? ___Date(s) _____
   Which side? Left ☐ Right ☐ Type of test: Physical ☐ Mammogram ☐ Ultrasound ☐ MRI ☐

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5. How many times have you been diagnosed with any type of non-cancer breast disease ? _____
   What disease were you diagnosed with? Fibro-Cystic ☐ Mastitis ☐ Dense ☐ Other: _____
   Which side? Left ☐ Right ☐ Date of diagnosis: _____

6. How many times have you been diagnosed with ovarian cancer? _____
   Date of Diagnosis: _____ Stage: 1 ☐ 2 ☐ 3 ☐ 4 ☐ Date of last treatment: _____

7. Have you had surgery for the removal of both ovaries? Yes ☐ No ☐ Date of surgery: _____

8. Have you ever had radiation treatments to your back or chest **not including chest x-rays or CT scans**? Yes☐ No ☐ Date of last treatment: _____

9. Have you gained more than 30 lbs since completing menopause? Yes ☐ No ☐ N/A ☐

10. Have any of your blood relatives been diagnosed with breast or ovarian cancer? Yes ☐ No ☐
    Mother ☐ Daughter ☐ Sister(s) ☐ Aunt(s) ☐ Cousin(s) ☐ Grandmother(s) ☐ Niece(s) ☐
    Other: _____ Were they diagnosed at the age of 40 or younger? Yes ☐ No ☐

11. Have you ever had a mammogram? Yes ☐ No ☐ Age of first mammogram: _____
    How many mammograms have you had? _____ Date of last mammogram: _____

12. What was your age at first menstrual period: _____

13. Have you had an endometrial ablation? (A procedure that destroys the uterine lining or endometrium). This does not include a D & C. Yes ☐ No ☐ Date: _____

14. Has it been 12 months or more since your last menstrual period? Yes ☐ No ☐
    Date of last period: _____ Were you age 55 or older on the date of last period? Yes☐ No ☐

15. Have you ever used hormone contraceptives? Yes ☐ No ☐ What age did you start taking them? ___
    How many years did you take them? _____
    Did you use them for 4 or more years before your first child? Yes ☐ No ☐

16. In the past 3 months, have you taken the following: Hormone contraceptives or prescribed hormone replacement therapy (HRT) **containing Estrogen** or do you currently have an IUD in place?
    Yes ☐ No ☐
    If yes, what is the name of the medication? _____

17. Have you taken prescribed estrogen (HRT) for 4 or more years after menopause? Yes ☐ No ☐

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18. Have you ever been pregnant? Yes ☐ No ☐ What was the age at your first pregnancy? _____
Have you ever given birth? Yes ☐ No ☐ Age at first childbirth: _____
Did you breast feed any of your children for more than six months? Yes ☐ No ☐

19. Are you pregnant now? Yes ☐ No ☐

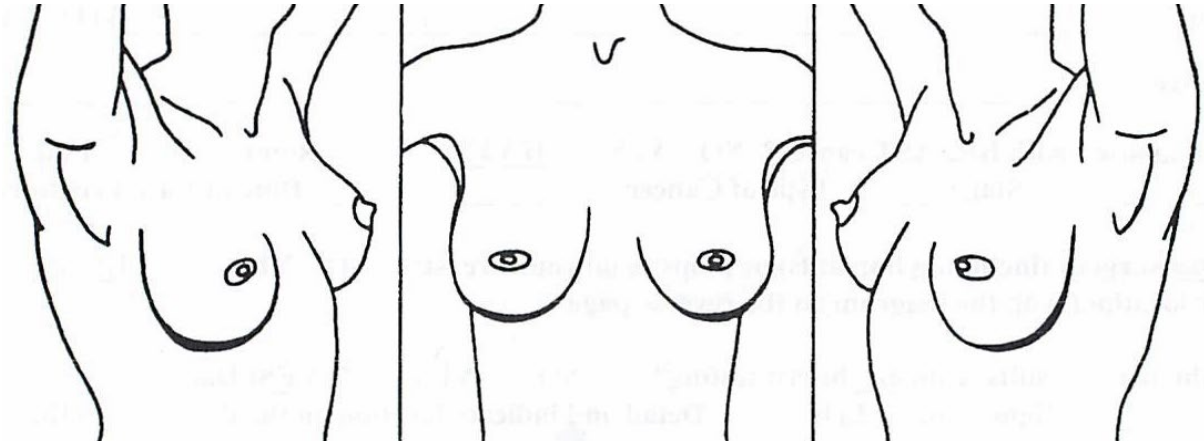
20. Are you currently breast feeding? Yes ☐ No ☐ How many months have you been breast feeding? _____ If any, which breast do you favor when feeding? Left ☐ Right ☐ Equal ☐

21. In the nipple area have you had any of the following symptoms in the past six months? Pain ☐ Tenderness ☐ Lumps ☐ Other symptoms: _____

22. Has a mammogram ever revealed that you have dense breasts? Yes ☐ No ☐
If yes, what category? C ☐ D ☐

Please indicate the symptoms that you have experienced in the past 6 months and indicate the specific area(s) related to your symptom(s) on this drawing.

Right Breast: Pain ☐ Tenderness ☐ Lumps ☐ Skin Thickening ☐ Discoloration ☐ Changes in Shape ☐ Changes in Size ☐ Rash ☐
Right Nipple: Discharge ☐ Discoloration ☐
Left Breast: Pain ☐ Tenderness ☐ Lumps ☐ Skin Thickening ☐ Discoloration ☐ Changes in Shape ☐ Changes in Size ☐ Rash ☐
Left Nipple: Discharge ☐ Discoloration ☐



Tech Notes:

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Patient Name: _____

Informed Consent and Release:

Your signature below will acknowledge that you have been offered, read and understand the Thermascan Reference Laboratory, LLC. Privacy Practices, Informed Consent, Authorization and Report Release; that you consent to the thermology procedure and instruct us to release your thermology report to the physician(s) and others you have specified on this form. Your signature also indicates you have complied with the preparation protocols as instructed.

Do you consent to the terms above? YES ☐ NO ☐

With this release you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information.

Do you consent to the terms above? YES ☐ NO ☐

Signature _____ Date _____