THERMA-SCAN™
REFERENCE LABORATORY, LLC.

Name_____
Last **First** **Middle**

Date of Birth_____AGE_____
For all questions below, if **YES**, please provide details, otherwise indicate **NO** and move on to the next question.

ID Code_____
(Office Use Only)

STUDY DATE_____
(Office Use Only)

Study Type ☐ **Routine** ☐ **STAT**

1. Previous thermology? ☐**NO** ☐**YES**

Date_____**Site**_____

2. Have you **ever** been diagnosed with ***breast cancer***?
☐ **NO** ☐**YES** **Date** of biopsy_____
Side: ☐**RIGHT** ☐**LEFT**
Stage ☐**0** ☐**1** ☐**2** ☐**3** ☐**4** ☐Unknown
Type: ☐**Ductal** ☐**Lobular** ☐**Inflammatory**
☐**Paget's** ☐**Phyllodes** ☐Don't Recall
Surgery ☐None ☐Lumpectomy ☐Mastectomy
Treatment ☐None ☐Radiation ☐Chemotherapy

Date of Last Treatment_____
Reconstruction:☐None ☐DIEP ☐Lat Dorsi flap
☐SGAP ☐TRAM flap ☐ Autologous fat graft
☐Implant ☐Other_____**Date**_____

3. Have you had non-cancer breast surgery? ☐ **NO**
☐ **YES** **Side**: ☐**RIGHT** ☐**LEFT**
☐Aspirations ☐Biopsy ☐Implants ☐Lift
☐ Reduction ☐Other_____

Date(s)_____

4. Have you had any ***abnormal*** results from breast testing? ☐**NO** ☐**YES** **Side**: ☐**RIGHT** ☐**LEFT**
☐ Physical ☐Mammogram ☐ Ultrasound ☐MRI

DATE(s)_____

5. Have you ever been diagnosed with any type of **non-cancer** breast disease? ☐**NO** ☐**YES**
Side: ☐**RIGHT** ☐**LEFT** **Type**: ☐ Fibro-Cystic
☐Mastitis ☐Other_____**Date**_____

6. Have you **ever** been diagnosed with ***ovarian*** cancer?
☐**NO** ☐ **YES** **Date** of diagnosis_____
Stage:☐**1** ☐ **2** ☐**3** ☐**4** ☐Unknown
Date of Last Treatment_____

7. Have you had surgery for the removal of ***both*** ovaries?
☐ **NO** ☐**YES** **Date** of Surgery_____

8. Have you ***ever*** had radiation ***treatments*** to your chest or back? ☐ **NO** ☐**Yes** **Date or Age**_____

9. Have you gained ***more*** than **30** pounds ***after*** you completed menopause? ☐**NA** ☐**NO** ☐ **YES**

10. Have **any** of your ***blood relatives*** been diagnosed with breast **or** ovarian cancer? ☐ **NO** ☐**YES**
☐Mother ☐Daughter(s) ☐ Sister(s) ☐Aunt(s)
☐Cousin(s) ☐Grandmother(s) ☐ Niece(s)
☐Other_____Were they diagnosed at the age of ***40 or younger***? ☐**NO** ☐**YES**
List Relationship and Age when Diagnosed

_____

11. Age at ***first*** mammogram_____ Total #_____

Date of ***last*** mammogram_____

12. Age at **first** menstrual period_____

13. Have you had endometrial ablation? ☐ **NO** ☐**YES**

Date (or age)_____

14. **Date** (or age) of your **last** menstrual period_____

15. Have you ***ever*** used hormone contraceptives?
☐**NO** ☐ **YES** Age started____How long_____
15a. Did you use these drugs 4 or more years ***before*** your first child? ☐ **NA** ☐ **NO** ☐**YES**

16. Have you taken contraceptives or **prescribed** hormone replacement therapy (HRT) containing **estrogen** in the past **three** (**3**) months? ☐ **NO** ☐ **YES**

Medication Name_____

17. Have you taken **prescribed estrogen** (**HRT**) **4** or more years? ☐ **NO** ☐**YES**

18. Age at **first** pregnancy____Age at **first** childbirth____

19. Are you ***now*** pregnant? ☐ **MAYBE** ☐ **NO** ☐ **YES**

20. Are you currently breastfeeding? ☐**NO** ☐**YES**
Breast Favored ☐**RIGHT** ☐**LEFT** ☐**EQUAL**
How Long?_____

21. Did you breast feed any of your children for more than **6** months? ☐**NA** ☐**NO** ☐ **YES**

Name_____
Last **First** **Middle**

Address_____
Number **Street** **Apt.**

_____
City **State** **Zip**

Phone_____**E-Mail**_____

Primary Physician_____ **DO MD**

Physician's Address_____
Number Street Suite

_____
City State ZIP Phone

Other Physician_____**DO MD**

Physician's Address_____
Number Street Suite

_____
City State ZIP Phone

INFORMED CONSENT and RELEASE

Your signature below will acknowledge that you have been offered, read and understand Therma-Scan Reference Laboratory, LLC. Privacy practices, Informed Consent, Participation in Scientific and/or Medical Studies and the 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.

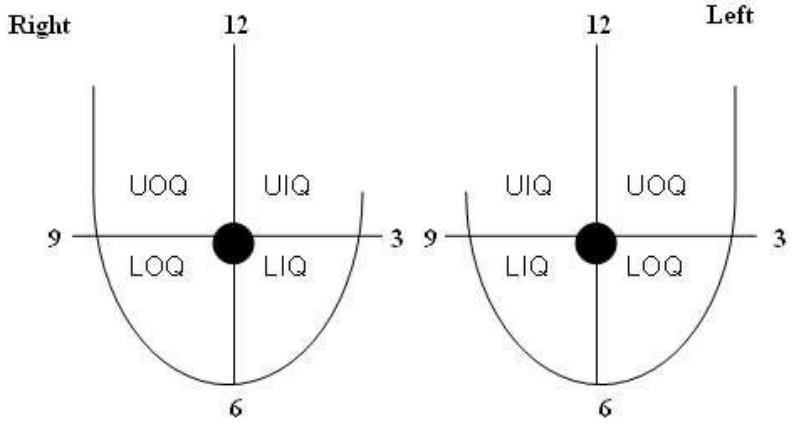
With this release you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information. ☐ **NO** ☐ **YES**

Signature:_____Date_____

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 ☐

Technician Notes:

Technician Initials: _____

Therma-Scan Reference Laboratory Use Only

Study # _____

R _____ **L** _____