# 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?** | ☐ | ☐ | _____ |
| **2. Ever been diagnosed w/ breast cancer? If yes, where? Date: Treatments:** | ☐ | ☐ | _____ |
| **3. Ever been diagnosed with any other breast disease (fibrocystic mastitis)?** | ☐ | ☐ | _____ |
| **4. Have you had any biopsies or surgeries to your breasts? If yes, where?** | ☐ | ☐ | _____ |
| **5. Have you had any breast cosmetic surgery or implants? If yes, what year?** _____ | ☐ | ☐ | |
| **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. Taken a contraceptive pill more than 1 year? If yes, how many yrs?** _____ | ☐ | ☐ | |
| **10. Have you suffered with cancer of the womb?** | ☐ | ☐ | |
| **11. Taken pharmaceutical hormone replacement? If yes, how many yrs?** _____ | ☐ | ☐ | |
| **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: _____

**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: _____