Thermography
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BREAST HEALTH HISTORY

Name: _____Age: _____ Date of Birth:_____

Address: _____ City: _____ Postal Code _____

Home Tel: _____ Work Tel: _____ Occupation: _____

E-mail _____ Marital Status: Single Married Common Law Divorced Widowed Separated

Number of Children: _____Referred by: _____

Do you have a family history of breast cancer? *Y* ☐ *N* ☐
Self ☐ *Mother* ☐ *Maternal* ☐ *Grandmother* ☐ *Sister* ☐ *Daughter* ☐ *None* ☐

Do you have any diagnosed breast conditions? *Y* ☐ *N* ☐
Fibrocystic ☐ *Cystic* ☐ *Other* _____

Have you previously had a thermogram? *Y* ☐ *N* ☐ *Date of most recent:*_____
Was it: *Normal* ☐ *Abnormal* ☐ *Suspicious* ☐ *Being watched: R Breast* ☐ *L Breast* ☐

Have you had a mammogram? *Y* ☐ *N* ☐ *Date of most recent:*_____
Was it: *Normal* ☐ *Abnormal* ☐ *Suspicious* ☐ *Being watched: R Breast* ☐ *L Breast* ☐

Have you had a breast ultrasound? *Y* ☐ *N* ☐ *Date of most recent:* _____
Was it: *Normal* ☐ *Abnormal* ☐ *Suspicious* ☐ *Being watched: R Breast* ☐ *L Breast* ☐

Have you had a breast exam by a doctor? *Y* ☐ *N* ☐ *Date of most recent:* _____
Was it: *Normal* ☐ *Lump Found: R Breast* ☐ *L Breast* ☐

Any breast biopsies? *Y* ☐ *N* ☐
When and what type *(i.e. needle, core)*? _____ *R Breast* ☐ *L Breast* ☐ *Both* ☐

Any breast surgeries? *Y* ☐ *N* ☐ *When and what was done?* _____ *R Breast* ☐ *L Breast* ☐ *Both* ☐

Have you had a mastectomy? *When?* _____*R Breast* ☐ *L Breast* ☐ *Both* ☐

Have you had radiation? *Y* ☐ *N* ☐ *When was it last performed?* _____ *R Breast* ☐ *L Breast* ☐ Both ☐

Have your had your ovaries removed? *Y* ☐ *N* ☐ *At what age?* _____

Do you have children *Y* ☐ *N* ☐ At what age was your first full term pregnancy? _____

Did you nurse for at least three months? *Y* ☐ *N* ☐ *How long* _____ Are you currently nursing? *Y* ☐ *N* ☐

Are you currently pregnant? *Y* ☐ *N* ☐ Are you currently taking birth control pills? *Y* ☐ *N* ☐
At what age did you start? _____ *for how many years?* _____

Are you in menopause? *Y* ☐ *N* ☐ At what age did it begin? _____

Have you ever taken synthetic hormone replacement *(ex. Premarin, Provera)* *Y*☐ *N*☐ _____
How many years taken? _____

Are you currently using natural progesterone cream? *Y*☐ *N*☐ Applied to: *Breasts only*☐ *Rotating body areas*☐

Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen? *Y*☐ *N*☐
*Explain:*_____

Do you feel that you are overweight? *Y*☐ *N*☐ How many pounds overweight?: _____

Are you experiencing any of the following with your breasts?

A lump *Y*☐ *N*☐ *Date found:* _____
Found by: *Self*☐ *Doctor*☐ *Found at: R Breast*☐ *L Breast*☐ *It is: Hard*☐ *Soft*☐ *Mobile*☐ *Tender*☐

Pain*: Y*☐ *N*☐ *(R*☐ *L*☐ *Both*☐*)* Is it: *Dull*☐ *Sharp*☐ *Burning*☐ *Stinging*☐ *Tender*☐ *Changes with my cycle*☐

Thickening: *Y*☐ *N*☐ *R Breast*☐ *L Breast*☐ *Both*☐

Skin changes: *Y*☐ *N*☐ *(Color*☐ *Texture*☐ *Over the lump*☐*)*

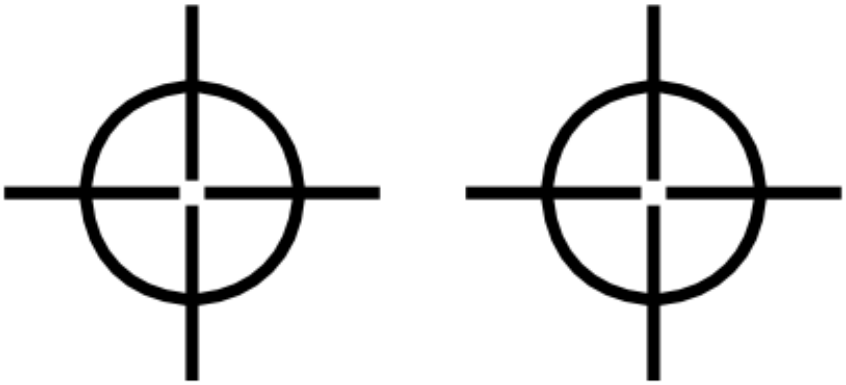
Nipple discharge: *Y*☐ *N*☐ *R Breast*☐ *L Breast*☐
Is it: *Bloody*☐ *Milky*☐ *Through one duct*☐ *Through multiple ducts*☐

Nipple retraction: *Y*☐ *N*☐ *R Breast*☐ *L Breast*☐

Nipple changes: *Y*☐ *N*☐ *R Breast*☐ *L Breast*☐ Change in: *Color*☐ *Texture*☐ *Other:* _____

_____

Place an [O] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [X] in the area of pain, tenderness, thickening, or skin changes:



RIGHT BREAST LEFT BREAST

Please note any other concerns/issues you may have: _____
_____

_____

_____

_____

_____

General Health Information

Do you have any medical complaints or conditions? *Y*☐ *N*☐ *Please explain:* _____

_____

Are you currently taking any medications? *Please list:*

Please circle all of the following conditions you have had:

Abscesses	Depression	Heart Disease	Mononucleosis	Rheumatic Fever	Syphilis
Addiction	Diabetes	Hepatitis	Mumps	Rubella	Tonsillitis
Allergies	Emphysema	Herpes Genitalia	Parasites	Scarlet Fever	Tuberculosis
Amnesia	Epilepsy	Influenza	Pelvic Inflammatory	Sexual Abuse	Typhoid Fever
Arthritis	Gall Stones	Kidney Disease	Disease	Skin Disease	Venereal Warts
Asthma	Goiter	Leukemia	Peritonitis	Strep Throat	Warts
Cancer	Gonorrhea	Malaria	Pleurisy	Sinusitis	Whooping Cough
Chicken Pox	Gout	Measles	Pneumonia	Sunstroke	Worms
Cold Sores	Hay Fever	Miscarriage	Prostatitis	Stroke	Yellow Fever

Other _____

Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? *Y*☐ *N*☐ *Explain?:*_____

_____

Have you had any operations? *Y*☐ *N*☐ *Which?:*_____

Have you lost any weight recently? *Y*☐ *N*☐ *How many pounds?*:_____

Do you exercise? *Y*☐ *N*☐ *How often?:*_____

Have you had any major injuries? *Y*☐ *N*☐ *Explain:* _____

Are you taking any of the following substances? *(which & how much):*
Tobacco: _____Alcohol: *(drinks per week)*_____Coffee: *(cups per day)*_____

Recreational Drugs *Y*☐ *N*☐ *Explain:* _____

Have any of the following ailments affected your relatives? *(circle all that apply)*

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

Family History	Age if alive	Age of death	Ailments
Mother			
Father			
Brother(s)			
Sister(s)			
Children			
Grandmother (maternal)			
Grandfather (maternal)			
Grandmother (paternal)			
Grandfather (paternal)			