

Name _____

DOB _____ Age _____ Hgt _____ Wgt _____

Street _____

Town _____

State, Zip _____

Occupation _____

E-mail _____

Phone (best #) (H, W, C) _____ May we leave a msg? Y N

Please send my report by: encrypted email CD Print

Reason for today's visit: _____

Symptoms: _____

Current Treatment: _____

Current Medication: _____

HEALTH HISTORY

Illnesses DX/Dates: _____

Surgeries/Dates: _____

Injuries/Dates: _____

Family History: _____

Do you want your report sent to your Health Care Provider? (circle one) Yes No

Providers name and address: _____

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

Signature: _____ Date: _____

For office use only:	
Patient ID# _____	Next Appt. _____
Report Ref # _____	BR1 BR2 BRA HB FB ROI
Referred by _____	
Send by _____	Sens uploaded _____ by _____
Data updated _____	called _____
RC _____	Pt rpt sent _____ HCP rpt sent _____
Pymt _____	ck # _____ VISA MC AMEX DISC

Breast Thermography Confidential Questionnaire

Name: _____ DOB: _____ Date: _____

- | | | |
|---|-----|----|
| 1. Do you have any close relative who has had breast cancer? | Yes | No |
| 2. Have you ever been diagnosed with breast cancer? | Yes | No |
| 3. Have you ever been diagnosed with any other breast disease (fibrocystic)? | Yes | No |
| 4. Have you had any biopsies or surgeries to your breasts? | Yes | No |
| 5. Have you had any breast cosmetic surgery or implants? | Yes | No |
| 6. Have you had a mammogram in the past 12 months? | Yes | No |
| 7. Have you had a mammogram in the past 5 years? | Yes | No |
| 8. Have you had abnormal results from any breast testing? | Yes | No |
| 9. Have you ever taken a contraceptive pill for more than 1 year? | Yes | No |
| 10. Have you suffered with cancer of the womb? | Yes | No |
| 11. Have you had pharmaceutical hormone replacement therapy? | Yes | No |
| 12. Do you have an annual physical examination by the doctor? | Yes | No |
| 13. Do you perform a monthly breast self exam? | Yes | No |
| 14. How many mammograms have you had in total? _____ | | |
| 15. What was your age when you had your first mammogram? _____ | | |
| 16. How many births have you had? _____ Your age at birth of first child: _____ | | |
| 17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____ | | |
| 18. Do you smoke? Yes__ No __ 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"/>
Others _____		

Authorization to Use or Disclose Protected Health Information

ThermoVision

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, Radiant Health Imaging, Inc. 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 Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of **Interpretation of said images**

Effective dates for this authorization: _____

This authorization will expire upon written request.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative _____
Date

Authorized Signature of Facility _____
Date

Patient Preparation Sheet/Full Body Scan

Purpose of test:

- Determine the cause of pain.
- Evaluate sensory-nerve irritation or significant soft-tissue injury.
- To define a previously diagnosed injury or condition.
- To identify an abnormal area for further diagnostic testing.
- For early detection of lesions.
- To monitor progress of healing and rehabilitation.
- To provide objective evidence.

Patient Preparation:

Prior to your appointment **do not** (on the day of):

- have physical therapy or electromyography
- use a tanning booth
- smoke for 2 hours before the test
- do not use lotions, powders, anti-perspirants, or makeup
- have strenuous exercise
- shave any part of your body
- perform skin brushing
- use therapeutic essential oils
- have kidney dialysis

Do not have acupuncture treatment or body work **3 days** prior to appointment. Wait **3 mos.** post surgery, radiation therapy, and chemo therapy. Wait **3 mos.** post lactation, before scheduling an appointment.

If your hair falls below your neck you should wear it clipped or pinned up.

Attire – Loose fitting clothes and no jewelry around the neck.

No changes necessary for diet or medication.

General Information:

Procedure - non-invasive, no-contact, no radiation and FDA Approved.

Disrobing - remove all clothing and jewelry. Put on a gown or sarong supplied. Inform your thermographer if you have/had any recent skin lesions on your body

Thermography is performed by a female certified clinical thermographer and is completely private. There are no risks or side effects to the procedure.

Average time for the appointment is 30 min. for one or two body regions, 1 hour for half or full body.

Please bring your healthcare providers complete name and address if you want a copy of report and scans mailed to him/her.

We gladly accept personal check, cash, Visa/ MC/Disc/Amex for payment.

You are welcome to bring a companion or partner to be present during the scan.



INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- ThermoVision and its staff of certified thermographers will use Digital Infrared Thermal Imaging (DITI) to take images of specified region(s) of my body as requested.
- these images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
- my images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) Inc. (thermology group). The Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.
- DITI is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
- the Report will not tell me whether I have any illness, disease or condition, but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.
- DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI).
- I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore I hold ThermoVision harmless as to the results and interpretations resulting from this process.
- ThermoVision will keep all information shared by me completely confidential unless I provide a release in writing or as required by law (HIPAA).

Acknowledgement

By signing below I certify that I have read and understand the statements above and consent to the examination.

Name (please print)

Date of Birth

Client Signature

Name, if other than client, and relationship to client