Acupuncture & Natural Healing Center | 772.781.5353 | 921 SE Ocean Blvd. Suite 2, Stuart, FL 34994

Confidential Questionnaire

- *Breast*

Name_____Birth Date_____Today's Date_____
Address_____City_____State___Zip_____
Phone Number Home_____Cellular_____Work_____
E-Mail Address_____
Referring Physician_____

Is there a specific reason or concern for this exam?

1. Have you recently had any of these breast symptoms? (Mark only if "yes")	LT	RT	Yes	No
Pain/Tenderness	○	○		
Lumps	○	○		
Change in breast size	○	○		
Areas of skin changes thickening or dimpling	○	○		
Excretions or changes of the nipple	○	○		

2. Are any of the above symptoms cycle related? ○ ○

3. Are you still having your periods? ○ ○
   If yes, date of last period_____

4. Have you had a surgical hysterectomy? ○ ○
   If yes, date_____ ○ Complete ○ Partial
   Reason for hysterectomy?
   ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? ○ ○
   If yes, note age and survival ○ Mother ○ Grandmother ○ Sister ○ Daughter
   Age diagnosed _____ Result of Treatment_____

6. Have you ever been diagnosed with breast cancer? ○ ○
   If yes, date Month_____Year_____

Cancer type	○ Local	○ Metastatic	○ Lymph node involvement	
Left breast	○ Inner	○ Outer	○ Nipple	
Right breast	○ Inner	○ Outer	○ Nipple	
Treatment	○ Surgery	○ Chemo	○ Radiation	○ None

7. Have you ever been diagnosed with any other breast disease? ○ ○
   If yes, ○ Cysts/fibrocystic ○ Fibro Adenoma ○ Mastitis/inflammatory breast disease

	Yes	No
8. Have you had any cosmetic breast surgery or implants?	○	○
If yes, date_____ ○ Silicone ○ Saline		
Experience: ○ Problems ○ No problems		
9. Have you ever had any biopsies or any other surgeries to your breasts	○	○
If yes, date_____		
Left breast ○ Inner ○ Outer ○ Nipple		
Right breast ○ Inner ○ Outer ○ Nipple		
Results ○ Negative ○ Positive ○ Calcifications		
10. Have you ever taken contraceptive pills for more than one year?	○	○
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years		
11. Have you had pharmaceutical hormone replacement therapy (HRT)?	○	○
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years		
12. Do you have an annual physical examination by a doctor?	○	○
13. Do you perform a monthly breast self exam?	○	○
14. Have you ever smoked?	○	○
15. Have you ever been diagnosed with diabetes?	○	○
16. Total mammograms____		
17. Date of last mammogram _____ Were you re-called?	○	○
18. Your age at your first mammogram?_____		
19. Number of full term pregnancies?_____		
20. Have you had breast ultrasound?	○	○
If yes…Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____		
21. Have you had breast MRI?	○	○
If yes…Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____		

Do you have any special concerns or are there any details related to the information above?

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination.

Patient Signature_____Date_____

How did you hear about us? _____