



IMS Breast Questionnaire

Patient Name

Last: _____ First: _____

Patient Details

Date of Birth: _____ / _____ / _____ **YYYY / MM / DD** Gender: [] male [] female

SSN: _____ / _____ / _____

Patient Contact Information

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ / _____ / _____ **YYYY / MM / DD** Work Phone: _____ / _____ / _____ **YYYY / MM / DD**

Study Info

Thermographer: _____

Imaging Date: _____ / _____ / _____ **YYYY / MM / DD**

Stat: []

Referring Physician Contact Information

Referring Physician: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ / _____ / _____ Fax: _____ / _____ / _____

General Notes: _____



1. Have you been diagnosed with breast cancer? [] Yes [] No

a. Date of diagnosis: _____ / _____ / _____ **YYYY / MM / DD**

b. Cancer was diagnosed on the:

Left Breast in stage: 0 1 2 3 4 unknown Right Breast in stage: 0 1 2 3 4 unknown

c. Type of cancer: [] Ductal [] Lobular [] Inflammatory [] Medullary [] Mucinous [] Paget's
[] Phyllode [] Tubular [] don't recall

d. Was a biopsy performed? [] Yes [] No

Date of biopsy: _____ / _____ / _____ **YYYY / MM / DD**

e. Did you have surgery? [] None [] Lumpectomy [] Mastectomy

Date of lumpectomy: _____ / _____ / _____ **YYYY / MM / DD**

Date of mastectomy: _____ / _____ / _____ **YYYY / MM / DD**

f. Did you have breast reconstruction? [] None [] Tram [] Flap [] Expander [] Other

Explain: _____

Date of reconstruction: _____ / _____ / _____ **YYYY / MM / DD**

g. Have you had treatments? [] None [] Radiation [] Chemotherapy

Date of last radiation treatment: _____ / _____ / _____ **YYYY / MM / DD**

Date of last chemotherapy treatment: _____ / _____ / _____ **YYYY / MM / DD**

2. Have you had any non-cancer breast surgery [] Yes [] No

a. Surgery was performed on the: [] Left Breast [] Right Breast

b. Type of surgery on the left breast: [] Biopsy [] Implants [] Reduction [] Other

Left breast other surgery was done on: _____ / _____ / _____ **YYYY / MM / DD**

Explain: _____

Left breast biopsy was done on: _____ / _____ / _____ **YYYY / MM / DD**

Left breast implant was done on: _____ / _____ / _____ **YYYY / MM / DD**

Left breast reduction was done on: _____ / _____ / _____ **YYYY / MM / DD**

c. Type of surgery on the right breast: [] Biopsy [] Implants [] Reduction [] Other

Right breast other surgery was done on: _____ / _____ / _____ **YYYY / MM / DD**

Explain: _____

Right breast biopsy was done on: _____ / _____ / _____ **YYYY / MM / DD**

Right breast implant was done on: _____ / _____ / _____ **YYYY / MM / DD**

Right breast reduction was done on: _____ / _____ / _____ **YYYY / MM / DD**

d. Specify implant type: [] Saline [] Silicone [] Other

Explain: _____

3. Have you ever been diagnosed with mastitis? [] Yes [] No

a. Mastitis was diagnosed on the: [] Left Breast [] Right Breast

b. Date of diagnosis: _____ / _____ / _____ **YYYY / MM / DD**

c. Type of treatment: _____

4. Have you ever been diagnosed with other breast disease? [] Yes [] No

a. Date of diagnosis: _____ / _____ / _____ **YYYY / MM / DD**

b. Breast disease was diagnosed on the: [] Left Breast [] Right Breast

c. Type of breast disease: [] Fibrocystic [] Other

Explain: _____

d. Have you ever undergone any treatment? [] Yes [] No

Date of treatment: _____ / _____ / _____ **YYYY / MM / DD**

5. Have you recently had abnormal results from a breast exam? [] Yes [] No

a. How was it detected?: [] Self Physical [] Infrared Mammogram [] X-Ray Mammogram
[] Ultrasound [] Breast MRI

b. Abnormal results on the: [] Left Breast [] Right Breast

c. Location of abnormal results on the left breast:

[] Upper Inner Quadrant [] Upper Outer Quadrant [] Lower Inner Quadrant [] Lower Outer Quadrant

d. Location of abnormal results on the right breast:

[] Upper Inner Quadrant [] Upper Outer Quadrant [] Lower Inner Quadrant [] Lower Outer Quadrant

e. Abnormal results found on: _____ / _____ / _____ **YYYY / MM / DD**

6. Have you ever been diagnosed with ovarian cancer? [] Yes [] No

a. Diagnosed on: _____ / _____ / _____ **YYYY / MM / DD**

b. Ovarian cancer was in stage: 1 2 3 4 unknown

c. Have you undergone treatment? [] Yes [] No

Date of last treatment: _____ / _____ / _____ **YYYY / MM / DD**

7. Have you had surgery for the removal of both ovaries? [] Yes [] No

a. Date of surgery: _____ / _____ / _____ YYYY / MM / DD

8. Has a blood relative had breast or ovarian cancer? [] Yes [] No

a. Which family members? [] Mother [] Daughter [] Sister [] Aunt [] Cousin [] Grandmother
[] Niece [] Other

Explain: _____

b. Were any family members diagnosed at age 50 or younger? [] Yes [] No

Which family members? [] Mother [] Daughter [] Sister [] Aunt [] Cousin [] Grandmother
[] Niece [] Other

9. Have you ever had any radiation treatments to your chest or back excluding chest x-rays (such as for treatment of Hodgkin's Disease)? [] Yes [] No

a. Date of treatment: _____ / _____ / _____ YYYY / MM / DD

10. Have you ever had an X-Ray mammogram? [] Yes [] No

a. How many X-Ray mammograms have you had in total? _____

b. What was your age at your first X-Ray mammogram? _____

c. Date of your last X-Ray mammogram: _____ / _____ / _____ YYYY / MM / DD

11. Did you have your first period at age 12 or younger? [] Yes [] No

a. At what age did you have your first period? _____

12. Date of your last menstrual period to your best recollection: _____ / _____ / _____ YYYY / MM / DD

13. Have you gained more than thirty (30) pounds of body weight after completing menopause?

[] Yes [] No [] n/a

14. Have you ever used hormone contraceptives (Pill, Norplant, Depo-Provera)? [] Yes [] No

a. What age did you start taking hormone contraceptives? _____

b. How many years have you taken hormone contraceptives in total? _____

c. Did you take hormonal contraceptives for 4 or more years total before your first child? [] Yes [] No

15. Have you ever been pregnant? [] Yes [] No

a. What was your age at your first pregnancy? _____

b. What was your age at your first childbirth? _____ [] N/A

16. Did you ever use fertility drugs? [] Yes [] No

17. Are you now taking other prescribed estrogen hormones (HRT)? [] Yes [] No

a. What type? [] Premarin [] Prempro [] Bio-Identical [] Other

Explain: _____

b. How is this applied? [] Vaginal [] Patches [] Cream [] Orally

18. Are you currently pregnant? [] Yes [] No [] Maybe

c. When did you become pregnant: _____ / _____ / _____ YYYY / MM / DD

19. Have you ever breast fed? Yes No

a. Are you currently breast feeding? Yes No

b. Which breast do you primarily breast feed with? Left Breast Right Breast Both Evenly

c. Did you breast feed any of your children for more than one month? Yes No

20. Have you ever had an infrared mammogram (thermology)? Yes No

a. Site name: _____

b. Date: _____ / _____ / _____ YYYY / MM / DD

c. Do you give Infrared Medical Solutions permission to obtain a copy of your previous infrared mammograms?
 Yes No

21. Have you recently had a discharge or secretion from your nipples? Yes No

a. Secretions from the: Left Breast Right Breast

b. Secretion type: Bloody Clear Milky Discolored Other

Explain: _____

22. Do you have any distortion of your nipples or areolas? Yes No

a. Distortion of the: Left Nipple/Areola Right Nipple/Areola

b. When did you first notice this change? _____ / _____ / _____ YYYY / MM / DD

23. Do you currently have any breast tenderness? Yes No

a. Tenderness on the: Left Breast Right Breast

b. Location of tenderness on the left breast:

Upper Inner Quadrant Upper Outer Quadrant Lower Inner Quadrant Lower Outer Quadrant

c. Location of tenderness on the right breast:

Upper Inner Quadrant Upper Outer Quadrant Lower Inner Quadrant Lower Outer Quadrant

24. Do you currently have any breast pain? Yes No

a. Pain on the: Left Breast Right Breast

b. Location of pain on the left breast:

Upper Inner Quadrant Upper Outer Quadrant Lower Inner Quadrant Lower Outer Quadrant

c. Location of pain on the right breast:

Upper Inner Quadrant Upper Outer Quadrant Lower Inner Quadrant Lower Outer Quadrant

25. Do you currently have any breast lumps? Yes No

a. When did you first notice this symptom? _____ / _____ / _____ YYYY / MM / DD

b. Lumps on the: Left Breast Right Breast

c. Location of lumps on the left breast:

Upper Inner Quadrant Upper Outer Quadrant Lower Inner Quadrant Lower Outer Quadrant

d. Location of lumps on the right breast:

Upper Inner Quadrant Upper Outer Quadrant Lower Inner Quadrant Lower Outer Quadrant

By checking on the boxes below, you indicate your acknowledgement and approval of the terms of this document.

Informed Consent

The thermographic procedure involves two series of images made of your chest with a special heat-imaging camera while you are unclothed before and after you place your hands in a basin of cool water. Thermographic imaging is completely passive (no radiation exposure and no physical contact) and can not harm you in any manner. The thermographic image data will be analyzed by specially trained medical professionals using a scientific method in order to obtain diagnostic indications that will be contained in a specific thermology report. The thermology report is not itself a diagnosis (medical conclusion) but will contain medical information that may be important in the process of obtaining a diagnosis. The process of obtaining a diagnosis must involve the professional services of your personal physician(s) and other forms of diagnostic evaluation. A normal thermology report does not eliminate all possibility of disease. An abnormal thermology report does not itself conclude the presence of disease. The diagnostic power of infrared mammography is additive with MRI, ultrasound, clinical examination and X-Ray mammography. We encourage you to obtain the substantial benefits of combining the appropriate tests for disease with the guidance of your personal physician(s). Infrared Medical Solutions can not function as your personal physician. Currently, thermology is not common practice in the United States and not all physicians in the US agree on the value of thermology. However, thermology has been recognized since 1971 by the US-HEW (currently the US-HHS) as a diagnostic procedure for breast disease, diseases of blood vessels and nerve-based diseases and has routinely demonstrated real value among various medical specialists.

As part of the anticipated treatment and diagnosis by your healthcare professional, it will be necessary for him/her to disclose personal health information to Infrared Medical Solutions related to the diagnostic imaging services that will be performed. In addition to any informed consent agreed to with your health professional, clicking on the box below constitutes an authorization granting Infrared Medical Solutions access to and use of personal health information. Such information shall be limited to diagnostic images taken by your healthcare professional as well as general background information that may aid in the diagnostic analysis of such images. Infrared Medical Solutions shall utilize this information to analyze the images taken and in consultation with your healthcare professional. The disclosure of such information shall be limited to Infrared Medical Solutions and your healthcare professional unless otherwise authorized by you and shall be used for diagnostic purposes only. Further, this release will also authorize Infrared Medical Solutions to disclose your thermology report to your designated health professional(s) and, if you so choose, yourself. This authorization may be revoked at any time by you upon written notice to Infrared Medical Solutions and your healthcare professional.

I have read this section, understand the terms, and agree to the thermology procedure.

Participation In Clinical Research

By clicking the first box below, you give permission for your thermographic images to be anonymously included in Infrared Medical Solutions medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information. If you do not wish to participate, click the second box below. This authorization may be revoked at any time by you upon written notice to Infrared Medical Solutions and your healthcare professional.

I have read this section, understand the terms and will Participate NOT Participate