



Clinical Thermography Ltd
99 Remuera Road, Remuera
Auckland 1050, New Zealand
Phone: (09) 522 0020
info@clinicalthermography.co.nz

Breast Health History

Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ Post Code: _____

Home Tel: _____ Work Tel: _____

Email: _____

Occupation: _____ Marital Status: S M D W SEP. Number of Children: _____

Referred By: _____

Where Did You Hear About Us?: _____

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

Y N Do you have any other diagnosed breast conditions?
 None Fibrocystic Cystic

Other _____

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

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

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

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

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

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

Y N Have you had a mastectomy? When? _____
 R L Breast

- Y N Have you had radiation? When was it last performed? _____ R L Breast
- Y N Have your had your ovaries removed? At what age? _____
- Y N Do you have children? At what age was your first full term pregnancy? _____
- Y N Did you nurse for at least three months? How long? _____
- Y N Are you currently nursing?
- Y N Are you currently pregnant?
- Y N Are you currently taking birth control pills? At what age did you start? _____
For how many years? _____
- Y N Are you in menopause? At what age did it begin? _____
- Y N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?
For how many years? _____
- Y N Are you currently using natural progesterone cream?
Applied to Breasts only Rotating body areas
- Y N Are you currently using herbal, homeopathic medicines, or supplements to stimulate or simulate estrogen? Please explain.

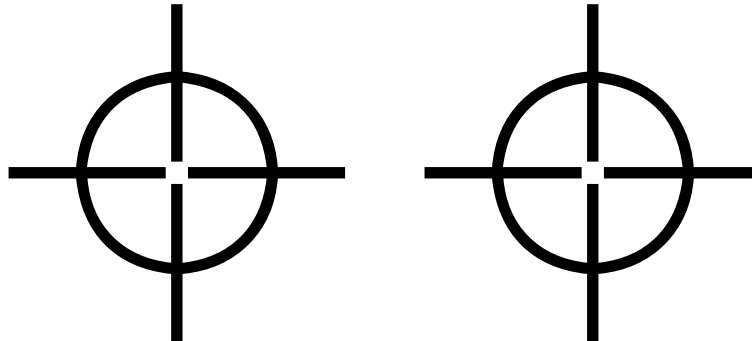
- Y N Do you feel that you are overweight? How many kilos overweight? _____

Are you experiencing any of the following with your breasts?

- Y N A lump. Date found: _____ by Self Doctor
It is: Hard Soft Mobile Tender
- Y N Pain. It is Dull Sharp Burning Stinging Tender Changes with my cycle
- Y N Thickening
- Y N Skin changes (Color Texture Over the lump)
- Y N Nipple discharge R L Breast
It is Bloody Milky Through one duct through multiple ducts
- Y N Nipple retraction R L Breast
- Y N Nipple changes R L Breast
Change in: Color Texture

Y N Other _____

If applicable, place an [O] on the diagram in the exact area of the lump, the finding on your mammogram, or the area being watched, and mark [X] in the area of pain, tenderness, thickening, or skin changes.



RIGHT BREAST

LEFT BREAST

Please note any other concerns or issues you may have:

General Health Information

Y N Do you have any medical complaints or conditions? Please explain.

Y N Are you currently taking any medications? Please list

Please circle all of the following conditions which 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 Disease | Sexual Abuse | Typhoid Fever |
| Arthritis | Gall Stones | Kidney Disease | Peritonitis | Skin Disease | Venereal Warts |
| Asthma | Goiter | Leukemia | Pleurisy | Strep Throat | Warts |
| Cancer | Gonorrhea | Malaria | Pneumonia | Sinusitis | Whooping Cough |
| Chicken Pox | Gout | Measles | Prostatitis | Sunstroke | Worms |
| Cold Sores | Hay Fever | Miscarriage | | Stroke | Yellow Fever |

Other: _____

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

Y N Have you had any operations? Please explain.

Y N Have you lost any weight recently? How many kilos?

Y N Do you exercise? How often?

Y N Have you had any major injuries? Please explain.

Y N Are you taking any of the following substances? How much?

Tobacco: _____ Alcohol: _____

Coffee: _____ Recreational Drugs: _____

Y N Have any of the following ailments affected any of your relatives?

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 at Death

AILMENTS

Mother:

Father:

Brothers:

Sisters:

Children:

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather: