BREAST HEALTH QUESTIONNAIRE

preferred method of contact:

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☐

Name: _____ Date of Birth: _____

Address: _____ Phone: Hm: _____

_____ Cell/Work: _____

G.P: _____ e-mail: _____

Office use only

General History:

Nationality: _____ Occupation: _____

Weight: _____ Height: _____ Age: _____

Menstrual History:

Age of onset: _____ Period length (days): _____ Length of monthly cycle: _____

Day of cycle today (day of appointment): _____ (Day 1 being the first day of bleeding)

Are you menopausal? Yes / No Age of onset? _____ Date of last period?_____

Hysterectomy: Yes / No Age: _____ Ovaries removed: Yes / No

Drugs:

Have you ever taken Oral Contraceptives/Mirena/Depo? Yes / No Age started: _____ Years taken: _____

Have you ever taken Synthetic Hormone Replacement Therapy? Yes / No I.V.F? Yes/No

If yes, please specify: _____ Years taken: _____

Have you ever taken Natural Hormone Replacement Therapy? Yes / No

If yes, please specify: _____ Years taken: _____

Are you taking any medication now? Please specify: _____

Are you taking any supplements now? Please specify: _____

_____

Pregnancies:

Age at 1st pregnancy: _____ Was first pregnancy to full term? Yes / No Are you pregnant now? Yes / No

Number of children breastfed 6 months or longer: _____ Breastfeeding now? Yes / No

Family History of Breast Cancer

Self _____ Maternal relatives: _____

Mother _____ Paternal relatives: _____

Sister _____ _____

Daughter _____ _____

Breast health history:

Office use only

Have you ever had a biopsy? Yes / No How many? _____ Benign/suspicious/malignant?

Needle biopsy _____ L / R Year: _____ Surgical biopsy _____ L / R Year: _____

Have you ever had:
Lumpectomy? Yes / No L R Year: _____

Mastectomy? Yes / No L R Year: _____

Radiation to breast: Yes / No L R Month : _____ Year: _____

Have you experienced blunt trauma to the chest? Yes / No Year: _____
Do you consistently use anti-perspirants? Yes / No

Date of last: Thermography _____ Mammography _____ Breast Ultrasound _____
Normal / Abnormal Normal / Abnormal Normal / Abnormal

Dental History:

Number of amalgams (silver fillings) : _____ Root canals: _____ Crowns: _____

Number of standard alcohol drinks per week: _____ or per month: _____

Consent for testing procedure

Infrared imaging is a non-contact test that demonstrates physiological patterns of your body. It is not a stand-alone diagnostic test. The information provided by your thermal scan is combined with your history to enable your practitioner to plan an approach to your care. Data collected may also be used for training or research purposes.

A licensed medical practitioner is the only person qualified to diagnose. He or she must combine thermographic studies with your additional clinical and testing information to determine your assessment. Infrared images provide evidence of thermal asymmetries that may be present. An asymmetry may be indicative of a vascular, neurological, muscular or other physiological problem.

I have read the above information and I understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that thermal imaging is non-invasive and is reading the thermal patterns on the surface of my body.* From this information a qualified practitioner will interpret any thermal abnormality displayed.

I understand that I am required to pay for this exam at the time of testing.

RESULTS: A copy will be sent to you within 1 – 2 weeks.

Please indicate how you would like your report sent:

PRINT AND SIGN YOUR NAME:

email: ☐ **post:** ☐ **extra copy (post)?** ☐

_____

Signature of Thermographic Technician:

_____ _____

Date: _____ Date: _____

www.clinicalthermography.co.nz thermography@godfreymedical.nz
1416a Cameron Road, Tauranga 3112 (0800) 102-888 (07) 543-0832

* In NZ, the National Screening Unit currently recommends that women aged 45 and over have screening mammograms every two years.