HCI Thermography

560 E Lanier Ave., Fayetteville, Ga 770-719-8785

Name _____ **Birth Date** _____
Address _____ **Email** _____
City / State_____ **Cell**_____

Explain all Yes answers briefly	**Yes**	**No**
Relative with breast cancer_____	____	____
Have you been diagnosed with breast cancer _____	____	____
Have you been diagnosed with other breast disease _____	____	____
Past Biopsy or Surgery to the breasts _____	____	____
Cosmetic surgery to breast _____	____	____
Mammogram in the last year _____	____	____
Mammogram in last 5 years _____	____	____
Abnormal results for any breast testing _____	____	____
Pill type Contraception for more than 1 year _____	____	____
Reproductive Cancer _____	____	____
Pharmaceutical HRT _____	____	____
Annual physical exam by a doctor_____	____	____
Do you perform a monthly breast exam _____	____	____

How many mammograms have you had _____ Age at the first mammogram _____
How many births have you had _____ Age at first birth _____
Menstruation before age 12 _____ Did cycles end after age 50 _____

Smoking: Yes _____ Never _____ Not in last year _____ Not in last 5 Years _____

Recent Breast Symptoms	**Right**	**Left**
Pain _____	_____	_____
Tenderness _____	_____	_____
Lumps _____	_____	_____
Change in breast size _____	_____	_____
Skin Thickening / Dimpling / Rashes _____	_____	_____
Secretions of Nipple _____	_____	_____

Cancer diagnosis

Date _____ Type _____ Metastatic _____
Lymph node involvment _____ Treatments _____
Location

Right _____	UO_____	UI_____	LO_____	LI_____
Left _____	UO_____	UI_____	LO_____	LI_____

Biopsy / Surgery

Location

Right _____	UO_____	UI_____	LO_____	LI_____
Left _____	UO_____	UI_____	LO_____	LI_____

I understand that the report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the report will not tell me whether I have illness, disease or other condition, but will be an analysis of images with respect only to the thermographic findings discussed in the report by the interpreting doctor. I authorize this office and its employees to use or disclose my patient health information to EMI for the specific purpose of interpretation of images. This authorization will be in force until i am no longer a patient at this office. I can revoke this authorization at any time in writing to this office.

Signature of Patient / Guardian _____ **Date**_____