| Phone: Cell Phone: Date of Birth: PHYSICIAN/S: When was the last breast exam by physician or nurse practitioner? Have you had any Mammograms? When? Results: Have you had any Dearst MR1s? When? Results: Have you had any Thermograms? When? Results: Have you had any Thermograms? When? Results: Age when you had your first period: Age of menopause: Are you currently pregnant? Y/N Are you currently pregnant? Y/N Are you currently pregnant? Y/N Are they spin-identical? Y/N How long have you taken them? If synthetic or bio-identical, what kind?: Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you naving regular periods? Y/N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left Porhow long? Lump/s / For how long? Lump/s / Pain / Appearance / Nipple fluid / Appearance / Nipple fluid / Other / Daughter / Other / Other / Sister / Daughter / Other / Right/Left Date: Breast Reduction Pease complete the dates for any of the following procedures or problems you have had: Right/Left Date: Surgical Breast Biopsy / Silicone Injections Lumpectomy for Cancer / Breast Hopsy / Silicone Injections Lumpectomy for Cancer / Breast Hopsy / Breast Injury to Breast (Chest/Neck) I understand that I will be responsible for payment at the time of services rendered. Client Signature: Date: Please indicate on the date anything noteworthy (pass problem, lump, infections etc.) | Your Age: Fi | irst Name: | Last Name: | | Date: |
|--|-----------------------|------------------------------|------------------|------------------------|------------------------------|
| Have you had any Mammograms? When? Results: Have you had any Detast MRI's? When? Results: Have you had any Ultrasound exams? When? Results: Results: Have you had any Ultrasound exams? When? Results: Results: Results: Age when you had your first period: Age of menopause: Are you currently pregnant? Y/N Are you currently pregnant? Y/N Are you currently taking hormones? Y/N How long have you taken them? Have you noticed any change's in your breast/s? Right/Left For how long? Lump's Have you noticed any change's in your breast/s? Right/Left For how long? Have you noticed any change's in your breast/s? Have you noticed any change's in your breast/s? Have you noticed any change's in your breast/s? Have you noticed any change's in your breast cancer? Have you have had: Have you have had: Right/Left Date: Right/Left R | Phone: | Cell Phone: _ | | Date of Birt | h: |
| Have you had any Mammograms? When? Results: Have you had any Detast MRI's? When? Results: Have you had any Ultrasound exams? When? Results: Results: Have you had any Ultrasound exams? When? Results: Results: Results: Age when you had your first period: Age of menopause: Are you currently pregnant? Y/N Are you currently pregnant? Y/N Are you currently taking hormones? Y/N How long have you taken them? Have you noticed any change's in your breast/s? Right/Left For how long? Lump's Have you noticed any change's in your breast/s? Right/Left For how long? Have you noticed any change's in your breast/s? Have you noticed any change's in your breast/s? Have you noticed any change's in your breast/s? Have you noticed any change's in your breast cancer? Have you have had: Have you have had: Right/Left Date: Right/Left R | When was the last by | roost axom by physician or | nursa practition | or? | |
| Have you had any breast MRI's? When? Results: Have you had any Utrasound exams? When? Results: Report Results: Report Results: Results | Have you had any M | lammograme? | When? | Reculte: | |
| Have you had any Ultrasound exams? | Have you had any br | react MRI's? | When? | Reculte: | |
| Have you had any Thermograms? | Have you had any U | ltrasound avams? | When? | Paculte: | |
| Age when you had your first period: Are you currently pregnant? Y/N Are you currently nursing? Y/N Are you currently taking hormones? Y/N Are you currently nursing? Y/N Are they bio-identical? Y/N How long have you taken them? If synthetic? Y/N How long have you taken them? If you have ever taken synthetic or bio-identical, what kind?: Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bio-identical hormones, please indicate what kind and for how long: Are you having regular periods? Y/N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left Por how long? Lump/s Thickening Pain Appearance Nipple fluid Other Has any blood relative had breast cancer? Yes / No Mother Sister Daughter Other Please complete the dates for any of the following procedures or problems you have had: Right/Left Date: Right/Left Date: Breast Reduction Breast Reduction Needle Biopsy Silicone Injections Radiation Therapy Injunts Replaced Mastectomy Mastitis/Abscess Cyst Aspiration Injury to Breast injury, sh as injury, sh problem, lump, infections Please indicate on the diagram where you have anything noteworthy (past presend) such as injury, sh problem, lump, infections Please indicate on the diagram where you have anything noteworthy (past presend) such as injury, sh problem, lump, infections Please indicate on the diagram where you have anything noteworthy (past presend) such as injury, sh problem, lump, infections Please indicate on the diagram where you have anything noteworthy (past presend) such as injury, sh problem, lump, infections Please indicate on the diagram where you have anything noteworthy (past presend) such as injury, sh problem, lump, infections | Have you had any T | hormograma? | When? | Posults: | |
| Are you currently pregnant? Y/N Are you currently taking hormones? Y/N Are they bio-identical? Y/N How long have you taken them? If synthetic? Y/N How long have you taken them? If synthetic or bio-identical, what kind?: Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you having regular periods? Y/N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left For how long? Lump/s Thickening / | | | | | |
| Are they bio-identical? Y/N How long have you taken them? Are they spinthetic? Y/N How long have you taken them? If synthetic or bio-identical, what kind?: Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you having regular periods? Y/N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left For how long? Lump/s Thickening / | Are you currently pr | egnant? V/N | Age of file | ou currently nursing? | |
| Are they bio-identical? Y/N How long have you taken them? Are they synthetic? Y/N How long have you taken them? If synthetic or bio-identical, what kind?: Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you having regular periods? Y/N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left For how long? Lump/s | | | The y | ou currently nursing. | 1 / 14 |
| If synthetic or bio-identical, what kind?? Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you having regular periods? Y / N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left For how long? Lump/s | | al? V/N | How 1 | ong have you taken tl | nem? |
| If synthetic or bio-identical, what kind?? Premarin/Prempro/Estrace/Evista/Tamoxifen/Birth Control If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you having regular periods? Y / N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left For how long? Lump/s | | Y/N | How I | long have you taken tl | nem? |
| If you have ever taken synthetic or bioidentical hormones, please indicate what kind and for how long: Are you having regular periods? Y / N Date of last period (Day 1 is date started): Have you noticed any change/s in your breast/s? Right/Left | | | | | |
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| Lump/s Thickening | | | | | |
| Thickening | | | • | | |
| Pain | Thickening | / | | | |
| Appearance Nipple fluid / Other | Pain | | | | |
| Nipple fluid Other | Appearance | / | | | |
| Other | | i | | | |
| Yes / No | * * | | | | |
| Mother | | | | | |
| Mother Sister Daughter Other Please complete the dates for any of the following procedures or problems you have had: Right/Left Right/Left Breast Reduction Surgical Breast Biopsy Heast Reconstruction Needle Biopsy Silicone Injections Heast Implants Radiation Therapy Mastectomy Mastitis/Abscess Cyst Aspiration Radiation Treatment Injury to Breast Master rendered. Right Right Right Right Date: Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections | · | | ge when diagnos | ed: | |
| Sister | Mother | | = | | |
| Daughter Other | Sister | | | | |
| Please complete the dates for any of the following procedures or problems you have had: Right/Left Date: Right/Left Date: | Daughter | 1 | | | |
| Right/Left Date: Breast Reduction | | / | | | |
| Breast Reduction | Please complete the | | wing procedur | | |
| Breast Reconstruction | D (D 1 () | Right/Left Date: | ς . | | |
| Silicone Injections | | / | | | |
| Breast Implants | | on/ | | | |
| Implants Replaced / Mastectomy / Mastitis/Abscess / Cyst Aspiration / Mastitis/Abscess / Cyst Aspiration / Mastitis/Abscess / Cyst Aspiration / Mastectomy / Mastitis/Abscess / Cyst Aspiration / Mastectomy / Mastec | 3 | | | | |
| Mastitis/Abscess/ Cyst Aspiration/ Radiation Treatment/ Injury to Breast/ (Chest/Neck) I understand that I will be responsible for payment at the time of services rendered. Client Signature: Date: Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections | • | | | 1.5 | |
| Radiation Treatment Injury to Breast (Chest/Neck) I understand that I will be responsible for payment at the time of services rendered. Client Signature: Date: Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections | | | | | |
| (Chest/Neck) I understand that I will be responsible for payment at the time of services rendered. Client Signature: Date: Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections | | | | | |
| Right Right Date: Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections | | | Injury | to Breast | _/ |
| Right Left Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections. | | will be responsible for pa | yment at the tin | ne of services render | ed. |
| Right Left Please indicate on the diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections. | Client Signature | | | Date: | |
| Right Left diagram where you have anything noteworthy (past present) such as injury, sk problem, lump, infections | enem signature | | · · · · · | <u></u> | Please indicate on the |
| present) such as injury, sk problem, lump, infections | | Diale | - 1 0 0 | | |
| problem, lump, infections | | Right | | Left | anything noteworthy (past of |
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Holistic Breast Health © 2013

| Name | | | Age: | |
|-----------------------|---|--|--------------------------|---------------------|
| Today's Date: | | Birth Date: | | |
| Address: | | | | |
| City: | | State: _ | Zip: | |
| Phone Numbers: | | | | |
| Who Referred You t | o our Practice? | | | |
| E | NCRYPTED REPO | ORTS ARE SENT TO CL | LIENTS VIA SHAREFIL | .E |
| E-mail Address: | | | | |
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| trained health care p | providers to assist in ide diagnosis of dis | evaluation report genera n evaluation, diagnosis a sease, eliminate the pos or self evaluation. | and treatment. I further | understand that the |
| Payment is due at til | me of services reno | dered. | | |
| | | | | |
| Client Signature: | | | Date: | |
| | | ymous use of my Ther nal Breast Health imagi | | for continued |
| Client Signature: | | | Date: | |