Your Age: _____ First Name: _____Last Name: _____Date:_____
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 breast MRI's? _____When? _____Results: _____
Have you had any Ultrasound exams? _____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 nursing? Y / N
Are you currently taking hormones? Y / N
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	___ / ___	_____
Thickening	___ / ___	_____
Pain	___ / ___	_____
Appearance	___ / ___	_____
Nipple fluid	___ / ___	_____
Other	___ / ___	_____

Has any blood relative had breast cancer?

	Yes / No	Her age when diagnosed:
Mother	___ / ___	_____
Sister	___ / ___	_____
Daughter	___ / ___	_____
Other	___ / ___	_____

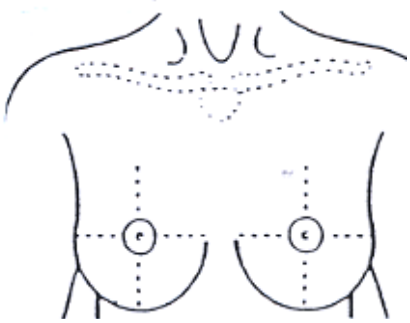
Please complete the dates for any of the following procedures or problems you have had:

	Right/Left	Date:		Right/Left	Date:
Breast Reduction	____/____	_____	Surgical Breast Biopsy	____/____	_____
Breast Reconstruction	____/____	_____	Needle Biopsy	____/____	_____
Silicone Injections	____/____	_____	Lumpectomy for Cancer	____/____	_____
Breast Implants	____/____	_____	Radiation Therapy	_____/___	_____
Implants Replaced	____/____	_____	Mastectomy	____/____	_____
Mastitis/Abscess	____/____	_____	Cyst Aspiration	____/____	_____
Radiation Treatment (Chest/Neck)	____/____	_____	Injury to Breast	____/____	_____

I understand that I will be responsible for payment at the time of services rendered.

Client Signature: _____ Date: _____

Right



Left

Please indicate on the diagram where you have anything noteworthy (past or present) such as injury, skin problem, lump, infections, etc.

Holistic Breast Health © 2013

Name _____ Age: _____

Today's Date: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: HOME: _____

CELL: _____

Who Referred You to our Practice? _____

ENCRYPTED REPORTS ARE SENT TO CLIENTS VIA SHAREFILE

E-mail Address: _____

I understand that the risk assessment evaluation report generated from my images are intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the report does not provide diagnosis of disease, eliminate the possibly that disease is present and that the report is not intended for self diagnosis or self evaluation.

Payment is due at time of services rendered.

Client Signature: _____ Date: _____

Optional: I give consent to the anonymous use of my Thermal Images and data for continued research and development of Thermal Breast Health imaging technology.

Client Signature: _____ Date: _____

Holistic Breast Health © 2013