THERMA-SCAN™
REFERENCE LABORATORY, LLC.

ID Code _____
(Office Use Only)

STUDY DATE _____
(Office Use Only)

Study Type ☐ Routine ☐ STAT

Name _____
Last First Middle

Date of Birth _____ AGE _____

For all questions below, if **YES**, please provide details, otherwise indicate **NO** and move on to the next question.

1. Previous thermology? ☐ **NO** ☐ **YES**

   Date _____ **Site** _____

2. Have you **ever** been diagnosed with ***breast cancer***?
   ☐ **NO** ☐ **YES** **Date** of biopsy _____
   Side: ☐ **RIGHT** ☐ **LEFT**
   Stage ☐0 ☐1 ☐2 ☐3 ☐4 ☐Unknown
   Type: ☐ **Ductal** ☐ **Lobular** ☐ **Inflammatory**
   ☐ **Paget's** ☐ **Phyllodes** ☐ Don't Recall
   Surgery ☐None ☐Lumpectomy ☐Mastectomy
   Treatment ☐None ☐Radiation ☐Chemotherapy

   Date of Last Treatment _____
   Reconstruction: ☐None ☐DIEP ☐Lat Dorsi flap
   ☐ SGAP ☐TRAM flap ☐ Autologous fat graft
   ☐ Implant ☐Other _____ **Date** _____

3. Have you had non-cancer breast surgery? ☐ **NO**
   ☐ **YES** **Side**: ☐ **RIGHT** ☐ **LEFT**
   ☐Aspirations ☐Biopsy ☐Implants ☐Lift
   ☐ Reduction ☐Other _____

   Date(s) _____

4. Have you had any ***abnormal*** results from breast testing? ☐ **NO** ☐ **YES** **Side**: ☐ **RIGHT** ☐ **LEFT**
   ☐ Physical ☐Mammogram ☐ Ultrasound ☐MRI

   DATE(s) _____

5. Have you ever been diagnosed with any type of **non-cancer** breast disease? ☐ **NO** ☐ **YES**
   Side: ☐ **RIGHT** ☐ **LEFT** **Type**: ☐ Fibro-Cystic
   ☐Mastitis ☐Other _____ **Date** _____

6. Have you **ever** been diagnosed with ***ovarian*** cancer?
   ☐ **NO** ☐ **YES** **Date** of diagnosis _____
   Stage: ☐1 ☐2 ☐3 ☐4 ☐Unknown
   Date of Last Treatment _____

7. Have you had surgery for the removal of ***both*** ovaries?
   ☐ **NO** ☐ **YES** **Date** of Surgery _____

8. Have you ***ever*** had radiation ***treatments*** to your chest or back? ☐ **NO** ☐ **Yes** **Date or Age** _____

9. Have you gained ***more*** than **30** pounds ***after*** you completed menopause? ☐ **NA** ☐ **NO** ☐ **YES**

10. Have **any** of your ***blood relatives*** been diagnosed with breast **or** ovarian cancer? ☐ **NO** ☐ **YES**
    ☐Mother ☐Daughter(s) ☐Sister(s) ☐Aunt(s)
    ☐Cousin(s) ☐Grandmother(s) ☐Niece(s)
    ☐Other _____ Were they diagnosed at the age of ***40 or younger***? ☐ **NO** ☐ **YES**
    List Relationship and Age when Diagnosed

    _____

    _____

11. Age at ***first*** mammogram _____ Total # _____

    Date of ***last*** mammogram _____

12. Age at **first** menstrual period _____

13. Have you had endometrial ablation? ☐ **NO** ☐ **YES**

    Date (or age) _____

14. **Date** (or age) of your **last** menstrual period _____

15. Have you ***ever*** used hormone contraceptives?
    ☐ **NO** ☐ **YES** Age started ____ How long _____
    15a. Did you use these drugs 4 or more years ***before*** your first child? ☐ **NA** ☐ **NO** ☐ **YES**

16. Have you taken contraceptives or **prescribed** hormone replacement therapy (HRT) containing **estrogen** in the past **three** (3) months? ☐ **NO** ☐ **YES**

    Medication Name _____

17. Have you taken **prescribed estrogen** (**HRT**) **4** or more years? ☐ **NO** ☐ **YES**

18. Age at **first** pregnancy ____ Age at **first** childbirth ____

19. Are you ***now*** pregnant? ☐ **MAYBE** ☐ **NO** ☐ **YES**

20. Are you currently breastfeeding? ☐ **NO** ☐ **YES**
    Breast Favored ☐ **RIGHT** ☐ **LEFT** ☐ **EQUAL**
    How Long? _____

21. Did you breast feed any of your children for more than **6** months? ☐ **NA** ☐ **NO** ☐ **YES**

Name _____
Last First Middle

Address _____
Number Street Apt.

_____
City State Zip

Phone _____ E-Mail _____

Primary Physician _____ DO MD

Physician's Address _____
Number Street Suite

_____
City State ZIP Phone

Other Physician _____ DO MD

Physician's Address _____
Number Street Suite

_____
City State ZIP Phone

INFORMED CONSENT and RELEASE

Your signature below will acknowledge that you have been offered, read and understand Therma-Scan Reference Laboratory, LLC. Privacy practices, Informed Consent, Participation in Scientific and/or Medical Studies and the Authorization and Report Release; that you consent to the thermology procedure and instruct us to release your thermology report to the physician(s) and others you have specified on this form. Your signature also indicates you have complied with the preparation protocols as instructed.

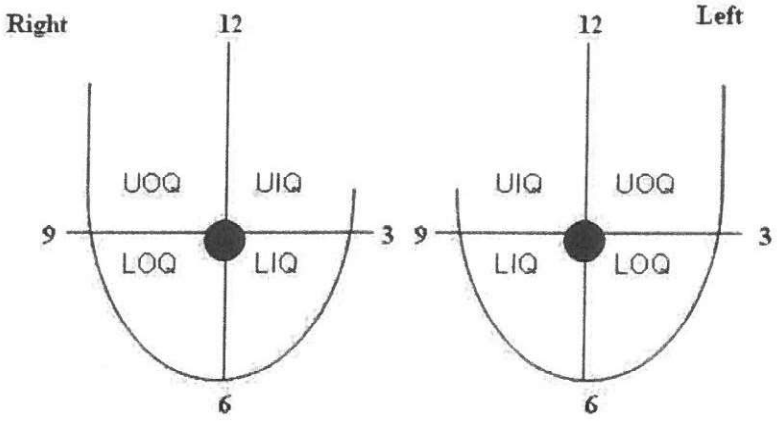
With this release you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information. ☐ NO ☐ YES

Signature: _____ Date _____

Please indicate the symptoms that you have experienced in the past 6 months and indicate the specific area(s) related to your symptom(s) on this drawing.

Right Breast
Pain ☐
Tenderness ☐
Lumps ☐
Skin Thickening ☐
Discoloration ☐
Changes in Shape ☐
Changes in Size ☐
Rash ☐

Right Nipple
Discharge ☐
Discoloration ☐



Left Breast
Pain ☐
Tenderness ☐
Lumps ☐
Skin Thickening ☐
Discoloration ☐
Changes in Shape ☐
Changes in Size ☐
Rash ☐

Left Nipple
Discharge ☐
Discoloration ☐

Technician Notes:

Technician Initials: _____

Therma-Scan Reference Laboratory Use Only

Study # _____

R _____ L _____