

## THERMAL IMAGING BREAST SCREENING REGISTRATION

<b>PATIENT ID:</b>
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**PERSONAL DETAILS**

First appointment date: \_\_\_ / \_\_\_ / \_\_\_

Surname:	Forenames:
Title: Mr /Mrs /Ms /Miss/Other	Date of birth: ___ / ___ / ___      Age:
Address:	
	Postcode:
Telephone (H):	(Mobile)
E-mail:	

Referred by: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

*A 10 minute report consultation with one of our thermographers is included in the price of your scan, or if you prefer your referring Practitioner may discuss your report with you instead.*

*Please tick here if you would prefer your practitioner to discuss your report with you*   

Are you a patient of Dr Daya?

In the past  currently  in the future (*I have made an appointment*)  No

**What is your preferred form of contact for reminders and messages? (please tick)**

By letter  By email  (address) \_\_\_\_\_

\*By landline  \*By mobile  \*Do you give us permission to leave a full message on this number (*stating the clinic name and a brief message on why we are calling you*)?

Yes

No

*We sometimes use test results from our patients in our research programme and when we do, this is in a completely anonymous way. It helps us make treatment advances in the work we are doing. Do you object to the anonymous use of your tests results for research purposes?*

*No, I do not object*

*Yes, I do object*

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## Breast Thermography Confidential Questionnaire

PATIENT ID:
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All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

	YES	NO
1. Do you have any close relative who has had breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been diagnosed with breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had any biopsies or surgeries to your breasts?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any breast cosmetic surgery or implants?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had a mammogram in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had a mammogram in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you had abnormal results from any breast testing?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever taken a contraceptive pill for more than 1 year?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you suffered with cancer of the womb?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had pharmaceutical hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have an annual physical examination by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you perform a monthly breast self exam?	<input type="checkbox"/>	<input type="checkbox"/>
14. How many mammograms have you had in total? _____		
15. What was your age when you had your first mammogram? _____		
16. How many births have you had? _____ Your age at birth of first child _____		
17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____		
18. Do you smoke?    Yes <input type="checkbox"/> Never <input type="checkbox"/> Not in last 12 months <input type="checkbox"/> Not in last 5 years <input type="checkbox"/>		
Have you recently had any of these breast symptoms:	Right breast	Left breast
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

**PATIENT ID:**

**Extended breast Questionnaire**

**Diagnosed with breast cancer: Yes/No**      **When diagnosed: Month/Year**

**Cancer type:** Metastatic       Local       Lymph node involvement

**Where (left breast):**

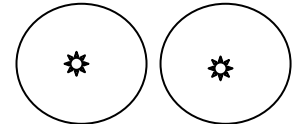
Upper Outer       Upper Inner       Lower Outer       Lower Inner       Nipple

**Where (right breast):**

Upper Outer       Upper Inner       Lower Outer       Lower Inner       Nipple

**Treatment:** Surgery       Chemo       Radiation       Other       None

**Please mark X to show location**



**Right Breast      Left Breast**

**Diagnosed with other breast disease:**      **When diagnosed: Month/Year**

**Disease type:** Fibrocystic       Cystic       Mastitis       Abscess       Other (please report other types of disease in the history) \_\_\_\_\_

**Breast biopsies or surgery:**      **When diagnosed: Month/Year**

**Where (left breast):** Upper Outer       Upper Inner       Lower Outer       Lower Inner       Nipple

**Where (right breast):** Upper Outer       Upper Inner       Lower Outer       Lower Inner       Nipple

**General Health Questions**

Please state below any diagnosed health conditions you have:

Please list any current symptoms you are experiencing:

Please state below what prescribed medication and/or nutritional supplements you are currently taking:

**Prescribed Medicines:**

**Nutritional Supplements:**

Are you vegetarian or vegan? Y/N      If yes how long for?

Do you eat red meat? Y/N

How many silver fillings do you currently have in your mouth? 1-2       4-6       A mouthful

Have you had any silver/amalgam fillings replaced? Y/N      If so when?

Do you use hair dye? Y/N      How often?

Do you dry skin brush? Y/N

If you smoke cigarettes, etc. how many do you smoke per day?

If you drink alcohol state daily consumption and type:

How much water do you drink per day?

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How often do you eat foods containing the following: (*e.g. daily/weekly/monthly/rarely*)

Dairy	Caffeine	Wheat
Sugar	Yeast	Potatoes
Do you drink tea and/or coffee? If YES how many	Cups of tea per day:	Cups of coffee per day:
Do you take sugar with your beverage? Y/N	Do you use artificial sweeteners ? Y/N	
Do you sleep well? Y/N	How many hours sleep do you get per night?	
Do you exercise?	If yes, what type of exercise & how often?	
If you are still having menstrual cycles, are your periods regular?		
When was your last menstrual period?	Where in your cycle are you right now?	
If you are post menopausal, when did you start the menopause?		
Are you currently taking HRT or the contraceptive pill?		
What is your weight?	Do you consider your weight to be:	Normal <input type="checkbox"/> Under <input type="checkbox"/> Over <input type="checkbox"/>
Do you consider yourself to be under stress? Y/N If so what type of stress?		

### ***PATIENT DISCLOSURE***

*I understand that the report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further 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 any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the report.*

- I consent to having a manual breast examination following my scan/ I do not want a manual breast examination (please delete as appropriate)*
- I would like a copy of my report to be sent to my referring practitioner. YES/NO*
- Finally, I understand that it is my own responsibility as the patient to choose whether to accept any treatment or test options professionally offered.*

*By signing below, I certify that I have read and understand the statements above and consent to the examination*

Signature \_\_\_\_\_

Today's date \_\_\_\_\_

### **A Positive Outlook**

Please remember that whilst Thermal Imaging is an excellent screening tool for early detection of underlying metabolic and physiological processes, it does not and cannot offer a diagnosis. Only a tissue biopsy can give a definitive diagnosis.

Early detection of heat abnormalities allows for proactive and holistic healthcare approaches to help reverse a potentially serious disease process.

We therefore encourage you to focus on these positive, proactive aspects. A snapshot into the invisible energy world, Thermal Imaging provides us with images that help motivate us to bring about basic lifestyle changes to reduce the toxic load on our body and encourage the healing process. These changes can be demonstrated using comparative analysis with Thermal Imaging over a period of time