



TRUE ADVANTAGE
IMAGING LLC

Confidential Questionnaire

Women's Full Body

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ (cellular) _____ (work) _____

Email _____ Physician's Name _____

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

Head & Neck

- 1. Do you suffer with headaches? ___ ___
 If yes, once a month or less ___ more than once a month ___
- 2. Do you have known allergies? Food ___ Environmental ___ ___ ___
- 3. Do you have TMJ or does your jaw click? ___ ___
- 4. Do you currently have a cold? ___ ___
- 5. Are you being treated for a thyroid disorder? Type _____ ___ ___
- 6. Do you have neck pain? ___ ___
- 7. Do you have upper back pain? ___ ___
- 8. Do you have a known history of carotid artery disease? ___ ___
- 9. Do you have a family history of stroke? ___ ___
- 10. Do you currently suffer with sinus problems? ___ ___
- 11. Do you have history of dental problems? ___ ___
 Root canals ___ Gum disease ___ Implants ___
 Non-replaced extractions ___ Dentures ___
- 12. Have you had dental cleaning in the past 7 days? ___ ___
- 13. Have you been diagnosed with elevated cholesterol? ___ ___

Do you have any special concerns or are there any details related to the information above?

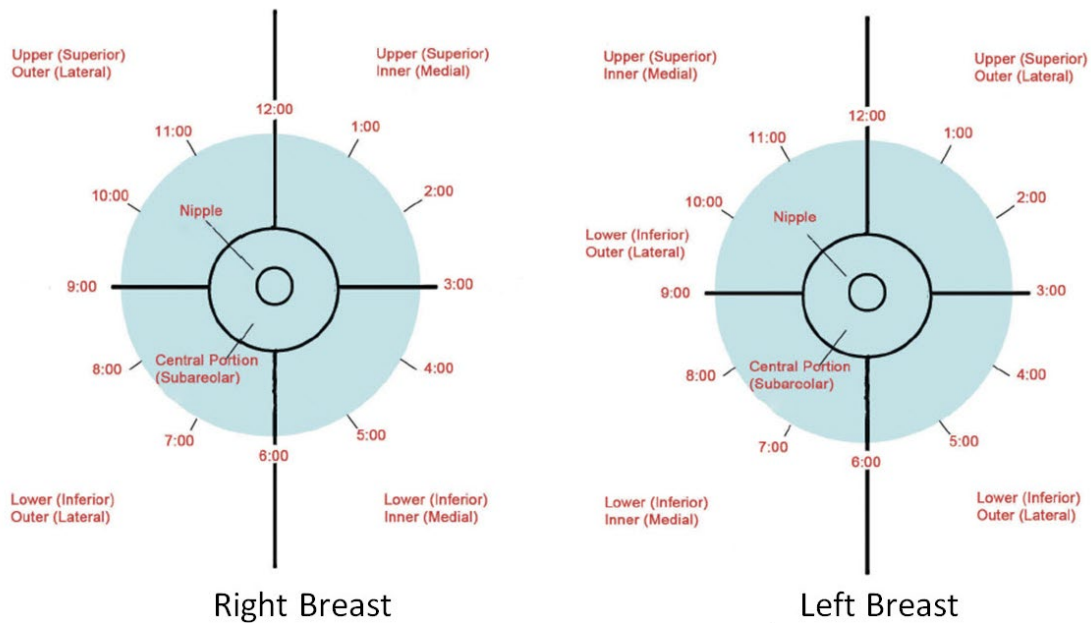
Breast

Is there a specific reason or concern for this breast exam?

	Yes	No
1. Have you recently had any of these breast symptoms? (Mark only if "yes")	___	___
LT RT		
Pain/Tenderness	___	___
Lumps	___	___
Change in breast size	___	___
Areas of skin changes thickening or dimpling	___	___
Excretions or changes of the nipple	___	___
2. Are any of the above symptoms cycle related?	___	___
3. Are you still having your periods? If yes, date of last period _____	___	___
4. Have you had a surgical hysterectomy?	___	___
If yes, date _____ Complete ___ Partial ___		
Reason for hysterectomy:		
<input type="radio"/> Excess bleeding <input type="radio"/> Endometriosis <input type="radio"/> Fibroid cysts <input type="radio"/> Cancer <input type="radio"/> Other		
5. Has anyone in your family ever been treated for breast cancer?	___	___
If yes, note age and survival <input type="radio"/> Mother <input type="radio"/> Grandmother <input type="radio"/> Sister <input type="radio"/> Daughter		
Age diagnosed _____ Result of Treatment _____		
6. Have you ever been diagnosed with breast cancer?	___	___
If yes, date: _Month _____ Year _____		
Cancer type <input type="radio"/> Local <input type="radio"/> Metastatic <input type="radio"/> Lymph node involvement		
Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple		
Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple		
Treatment <input type="radio"/> Surgery <input type="radio"/> Chemo <input type="radio"/> Radiation <input type="radio"/> None		
If surgery; <input type="radio"/> Mastectomy <input type="radio"/> Lumpectomy		
7. Have you ever been diagnosed with any other breast disease?	___	___
If yes, Cysts/fibrocystic ___ Fibro Adenoma ___		
Mastitis/inflammatory breast disease ___		
8. Have you had any cosmetic breast surgery or implants?	___	___
If yes, date _____ <input type="radio"/> Silicone <input type="radio"/> Saline		
Experience: <input type="radio"/> Problems <input type="radio"/> No problems		
9. Have you ever had any biopsies or any other surgeries to your breasts	___	___
If yes, date _____		
Left breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple		
Right breast <input type="radio"/> Inner <input type="radio"/> Outer <input type="radio"/> Nipple		
Results <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Calcifications		

Mark on the following graph to indicate location of pain, surgery or lumps:

Clock and Quadrants of the Breast



Yes No

- | | | |
|--|-------|-------|
| 10. Have you ever taken contraceptive pills for more than one year?
If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years | _____ | _____ |
| 11. Have you had pharmaceutical hormone replacement therapy (HRT)?
If yes, <input type="radio"/> Currently <input type="radio"/> Less than 5 years <input type="radio"/> More than 5 years | _____ | _____ |
| 12. Do you have an annual physical examination by a doctor? | _____ | _____ |
| 13. Do you perform a monthly breast self-exam? | _____ | _____ |
| 14. Have you ever smoked? | _____ | _____ |
| 15. Have you ever been diagnosed with diabetes? | _____ | _____ |
| 16. Total mammograms _____ | | |
| 17. Date of last mammogram _____ Were you re-called? | _____ | _____ |
| 18. Your age at your first mammogram: _____ | | |
| 19. Number of full term pregnancies: _____ | | |
| 20. Have you had breast ultrasound?
If yes...Date: ____/____ Left ____ Right ____ Results: Negative ____ Positive ____ | _____ | _____ |
| 21. Have you had breast MRI?
If yes...Date: ____/____ Left ____ Right ____ Results: Negative ____ Positive ____ | _____ | _____ |

Chest, Heart & Lungs

- | | Yes | No |
|---|------------|-----------|
| 1. Have you been diagnosed with: | | |
| Heart disease? | ___ | ___ |
| Lung disease? | ___ | ___ |
| Upper spine disorders? | ___ | ___ |
| 2. Do you suffer with upper back pain? | ___ | ___ |
| 3. Do you suffer with chest pain? | ___ | ___ |
| 4. Have you been diagnosed with scoliosis? | ___ | ___ |
| 5. Have you ever had surgery to your: | | |
| Heart? | ___ | ___ |
| Lungs? | ___ | ___ |
| Mid to upper back? | ___ | ___ |
| 6. Do you have asthma or shortness of breath? | ___ | ___ |
| 7. Do you currently smoke? | ___ | ___ |
| 8. Have you smoked in the past 5 years? | ___ | ___ |
| 9. Do you suffer with shoulder pain? If yes, mark below | ___ | ___ |

Abdomen & Lower Back

1. Do you suffer with acid reflux or other digestive problems? Yes No	3. Have you had surgery or disease in the:
2. Do you suffer pain in the:	Stomach? Yes No
Stomach? Yes No	Spleen(Upper Left) ? Yes No
Below R Breast? Yes No	Liver(Upper Right) ? Yes No
Below L Breast? Yes No	Kidneys ? Yes No
Abdomen? Yes No	Intestines ? Yes No
Lower Back? Yes No	Abdomen ? Yes No
Pelvic Region? Yes No	Lower Back? Yes No
	Pelvic Region? Yes No

4. Have you consumed alcohol in the past 24 hours? Yes ___ No ___

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	2. Have you had Surgery to:
Leg? LT RT	Leg? LT RT
Sciatica LT RT	Sciatica? LT RT
Buttocks/Hip? LT RT	Buttocks/Hip? LT RT
Knees? LT RT	Knees? LT RT
Ankles? LT RT	Ankles? LT RT

Feet?	LT	RT	Feet?	LT	RT
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Arms & Hands

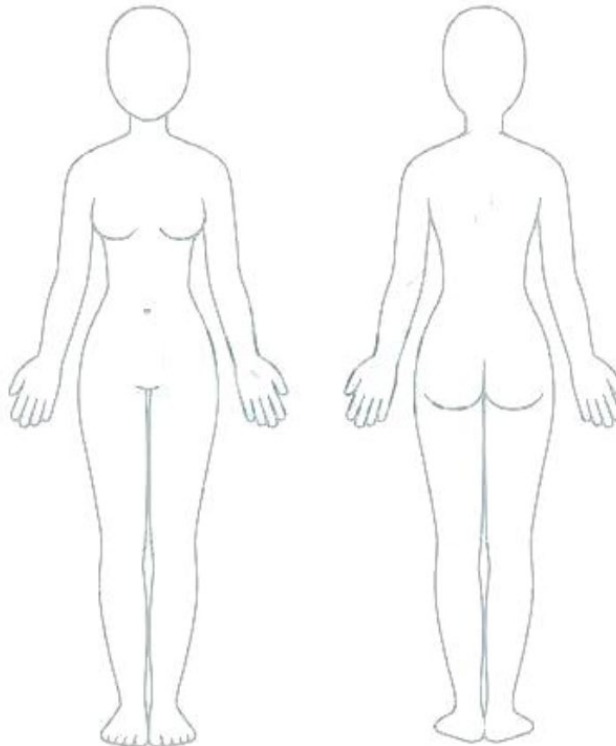
(Check only if "yes")

- | | | | |
|--|---|---|---|
| <p>1. Do you suffer with pain in the:</p> <p>Shoulder? _____</p> <p>Elbow? _____</p> <p>Arm? _____</p> <p>Hands? _____</p> | <p>LT RT</p> <p>____</p> <p>____</p> <p>____</p> <p>____</p> | <p>2. Have you had surgery to:</p> <p>Shoulder? _____</p> <p>Elbow? _____</p> <p>Arm? _____</p> <p>Hands? _____</p> | <p>LT RT</p> <p>____</p> <p>____</p> <p>____</p> <p>____</p> |
|--|---|---|---|

Do you have any special concerns or are there any details related to the information above?

Areas of Pain

Mark on the following graph to indicate location of pain, surgery or injury:



Areas of Pain

Do you have any special concerns or are there any details related to the information above?

Breast Thermography Study

Client Disclosure

Breast thermography is a non-contact, private and non-invasive procedure. The value of thermography as a study tool is its ability to measure skin temperature changes. **It offers men and women information that no other procedure can provide regarding breast health.**

Breast thermography is not a replacement for or alternative to mammography or any other form of breast imaging. Breast thermography, mammography or breast ultrasounds are complementary procedures; one **test does not replace the other.** Breast thermography is meant to be used in addition to other tests or procedures.

Thermography captures and records temperature variations on the skin, which provides vital information directly influenced by complex metabolic and vascular activity. This information **does not in any way suggest diagnosis and/or treatment.** Studies show that the patient benefits when multiple tests are used together. This multimodal approach includes breast self-examinations, physical breast exams by a doctor, mammography, ultrasound, MRI, thermography, and other tests that may be ordered by your doctor.

A reported “Elevated Level of Concern” finding does not indicate that it is suspicious for any specific disease. However, any suspicious finding will be accompanied with a strong and intentional recommendation for further clinical evaluation. If you detect a lump or any other change in your breast before your next thermogram study, consult your doctor immediately.

Notice to clients presenting with previously diagnosed cancer: Thermography interpretation in your report **does not include information or recommendations related to the measured changes of disease beyond skin temperature changes and patterns.** As there is no single known test capable of monitoring all biological influences of the complex disease generally diagnosed as cancer, **continued monitoring with available additional testing as recommended by your personal physician is strongly advised.** Your Thermographer may not be a licensed medical professional. **Your Thermographer cannot interpret your images or advise or prescribe to you based on your images.** Your thermographer can ask health history questions as well as educate you on general breast health.

By Signing below, I certify that I have read and understand the statement above and consent to the examination. I am not an undercover agent or acting on behalf of law enforcement.

Client Signature _____ Today's Date _____

