Thermal Imaging of Morton

112 E Queenwood; Morton, IL 61550

Patient Intake Form

For office use only:

Patient ID# _____

Report Ref # _____ BR ROI HB FB

Referred by _____

Scans sent_____Called _____

Pt rpt sent_____HCP rpt sent _____

Name _____DOB_____

Age ___ Gender___E-mail_____

Marital Status: M S W D Occupation _____

Street_____

City, State, Zip_____

Phone (Home) _____ (Work) _____(Cell) _____

Reason for today's visit: _____

_____

Current Symptoms:_____

_____

_____

Current Treatment: _____

_____

Previous illnesses: _____

_____

Have you ever had a Mammogram? Yes No If yes, when was the last one? _____

Have you ever had an abnormal Mammogram? Yes No If yes, list any follow-up testing procedures:

_____

Previous Surgeries/Dates: _____

_____

Skin Lesions or Physical Abnormalities: _____

Injuries/Dates: _____

Current Medication(s): _____

Dental History: (abscesses, implants, etc)_____

Have you had a vaccination in the past 4 weeks? Yes No (circle one) Right Arm Left Arm

Do you want your report sent to your Health Care Provider? (circle one) Yes No

Provider's name and address: _____

_____

_____

Do you give permission for the staff of Dimensional Health to review your report? (circle one) Yes No
(You will need to answer "Yes" if you would like us to answer any questions regarding your report).

This information is confidential. All information is correct to my knowledge.

Signed: _____ Date: _____

Confidential Questionnaire for Women's Health Check

NAME_____

Date of Birth_____

Please mark YES or NO as it applies to you:	**YES**	**NO**
Any close relative ever had breast cancer?		
Ever been diagnosed with breast cancer? **L R** Date:		
Diagnosed with any other breast disease? (Fibrocystic, Mastitis, Cystic, Abscess)		
Any biopsy or surgery to your breasts? **L R** Date:		
Cosmetic surgery to breasts? (implants, reduction, lift) **L R Both** Date:		
Do you have dense breast tissue?		
Have you had a mammogram in the past 12 months?		
Have you had more than 30 mammograms in your lifetime?		
Mammogram in the past 5 years? Date of most recent mammo or US:		
Any abnormal results from any breast testing?		
Ever taken a contraceptive pill for more than 4 years? How long?		
Ever diagnosed with ovarian, uterine or cervical cancer?		
Ever taken hormone replacement therapy? (pharmaceutical or bio-identical)		
Do you have an annual physical **breast** examination by a doctor?		
Do you perform a monthly breast self-exam?		
Did your periods start before the age of 12?		
Did your periods end after the age 50?		
Are you still having a menstrual cycle?		
Have you ever given birth to a child?		
Have you ever smoked for more than 5 years?		
Is your menstrual cycle irregular?		
Do you experience cramping during your menstrual cycle?		
Do you have heavy bleeding with your menstrual cycle?		
Do you have breast pain or tenderness that comes and goes?		
Do you have any breast lumps that come and go?		
Do you have low libido? (low sex drive)		
Do you have hot flashes?		

Please mark YES or NO as it applies to you	YES	NO
Have you ever been diagnosed with endometriosis?		
Have you ever been diagnosed with PCOS (poly cystic ovarian syndrome)?		
Have you ever been treated for infertility?		
Do you have any swelling in the neck or trouble swallowing?		
Any thyroid disorder? (hypothyroid/ hyperthyroid/ Hashimoto's/ Grave's disease)		
Do you regularly experience fatigue?		
Have you experienced recent hair loss?		

Have you **recently** had any of these breast symptoms?

Mark Right Breast or Left Breast as it applies	Right Breast	Left Breast
Pain		
Tenderness		
Lumps		
Change in breast size		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Have you had any type of vaccination in the last 4 weeks? LEFT ARM ☐ RIGHT ARM ☐ NO ☐

PATIENT DISCLOSURE:

I understand that the Report generated from my images is intended for use by trained healthcare 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.

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

Signature _____ Date _____

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Patient Review of Body Systems

Name: _____ Date: _____

Constitutional

___Fevers/Chills/Sweats

___Unexplained weight loss/gain

___Fatigue/weakness

___Excessive thirst or urination

Musculo-Skeletal

___Muscle/Joint Pain

Ears/Nose/Throat

___Difficulty hearing/ringing

___Hay Fever/Allergies

Cardiovascular

___Chest Pain/Discomfort

___Leg Pain w/Exercise

___Palpitations

Other (please specify)

Dental

___Extractions

___Crowns

___Root Canal

___Gum Disease

___Fillings

___Other

Respiratory

___Cough/Wheeze

___Difficulty Breathing

Gastrointestinal

___Heartburn/Reflux

___Nausea/Vomiting/Diarrhea

___Large bowel dysfunction

___Abdominal Pain

Skin

___Rash or Mole

Neurological

___Numbness

___Headaches

Organ Dysfunction

_____

_____

Blood/Lymphatic

___Unexplained Lumps

___Easy Bruising

_____

General Medical History: Past and Current medical problems (please include dates)

___Heart Disease: (specify)

___Diabetes

___Asthma/Lung Disease

___Accidents

___Other: (specify)

___High Blood Pressure

___Thyroid Problem

___Chemical Exposure

___Injuries

___High Cholesterol

___Kidney Disease

___Cancer: (specify)

_____

_____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

___High Cholesterol

___Heart Disease

___Bleeding or Clotting

___Asthma/COPD

___Cancer: type _____

___High Blood Pressure

___Stroke

___Genetic Disorders

___Other

___Diabetes

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Pain Chart

Name:_____ Date _____

Please use the symbols below to indicate areas of:

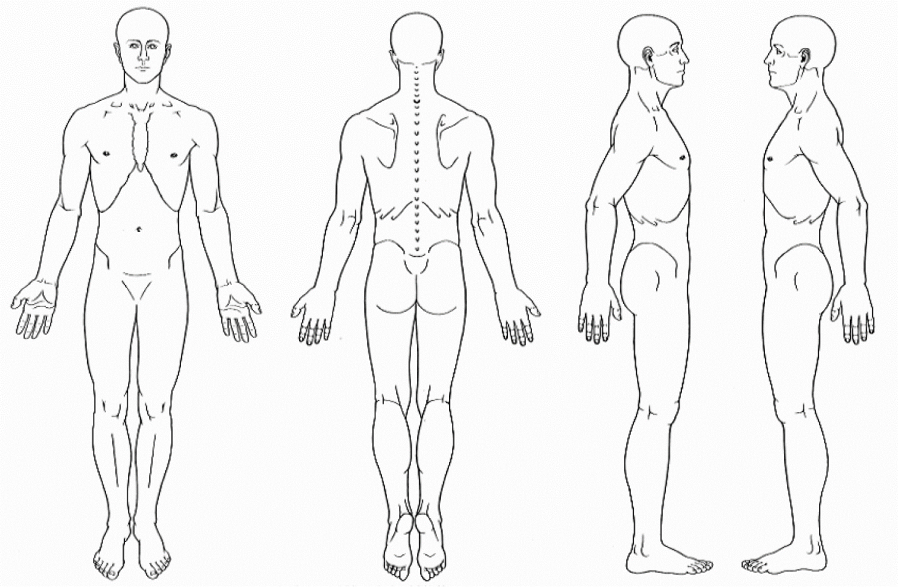
Main Pain ●

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scarring ↗



Do you know what triggered the pain?

_____

Does anything relieve it?

_____

_____

Does anything aggravate it?

_____

_____

Has it changed since it began?

_____

Have you had any treatment?

_____

_____

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Signature_____

Patient Preparation Sheet

Full Body or Region of Interest Health Screening with Clinical Thermography

Purpose of Test

- Determine the cause of pain
- Evaluate sensory-nerve irritation or significant soft-tissue injury
- To define a previously diagnosed injury or condition
- To identify an abnormal area for further diagnostic testing
- For early detection of lesions
    - -To monitor progress of healing and rehabilitation
    - -To provide objective evidence

Patient Preparation

Prior to your appointment **Do Not** (on the day of):

- use lotions, powders, or deodorant (of any kind)
- use makeup (for any scan that includes the head)
- have physical therapy or electromyography
- use a tanning bed and avoid overexposure to the sun
- use a sauna
- use a seat warmer in a car
- smoke for 2 hours before the test
- have strenuous exercise
- shave part of your body being scanned
- perform skin brushing
- use essential oils
- have body work done (chiropractic, massage, etc.)
- have kidney dialysis
- **Do Not** have acupuncture treatment **in the past three days**
- **Wait at least 3 months** after having surgery
- **Wait 6 months** after having radiation therapy

Please note, if you are pregnant or breastfeeding you must wait three months after you last gave birth/breast fed before getting a breast thermography scan

No changes necessary to diet or medication

General Information

Procedure - Non-invasive, no contact, no radiation, and FDA Approved

Disrobing - Remove all clothing and jewelry. Put on a gown or sarong supplied.

Thermography

- Performed by a certified clinical thermographer and is completely private
- No risks or side effects
- Average appointment time is 30 minutes for 1 or 2 body regions, and 1 hour for half or full body
- Bring your healthcare providers complete name and address if you want a copy of report mailed to him/her

You are welcome to bring a companion or partner to be present during the scan.