Office Use Only!

Filed: ___________________________

Mailed: __________________________

Baseline Report

Name: ________________________________ ___________________ D.O.B. _________________

Address: ____

City: ____ ST: _____ Zip: ____________

Phone: ____________________________ (Best #) E-mail: ________________________________

Occupation: ____

How did you hear about us:____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

Thermography Rio Grande Valley uses a Meditherm Digital Infrared Thermal Imaging (DITI) camera to provide a 15 minute non-invasive test of physiology. DITI detects the minute physiologic changes that accompany breast pathology.

I understand that Thermography RGV does not provide a medical diagnosis, but simply acts as the clinical thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to Thermography RGV. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider. A doctor to doctor consultation can be arranged between Meditherm and your doctor if necessary.

I give my permission for the **Thermography Rio Grande Valley** to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician.

Doctor's Name_____________________________________.

Date ______________________

Client's Signature ________________________

Date ______________________

Thermographer's Signature ___________________________

All Clinical Thermographers are trained and certified by the ACCT.

Patient Name: ____ **DOB:** ___________________

Significant Past Illnesses:

Illness	*Year(s)*	*Comments*

Previous Surgeries Especially Breast and Dental Surgeries:

Type of Surgery	*Year(s)*	*Comments*

Present Health Problems *(please indicate current concerns and/or symptoms)*:

Medical Problem	*Date of Onset*	*Comments/Concerns/Symptoms*

Present Medications:

Medication Name	*Taken For*	*Date Started*

Family Medical History:

	Age if Living	Age at Death	Cause of Death	Major Medical Health Problems (Bubble in all that apply)
Mother				○ Breast Cancer ○ Cancer ○ Stroke ○ Heart Attach/MI ○ Hypertension ○ Other (specify):___________________
Father				○ Breast Cancer ○ Cancer ○ Stroke ○ Heart Attach/MI ○ Hypertension ○ Other (specify):___________________

Do you participate in regular *(annual/bi-annual)* dental visits? ○ Yes ○ No

General overall health currently: ○ Excellent ○ Good ○ Fair ○Poor

If *fair* or *poor*, please explain: ____
____

Other Current Treatments: ____
____

Extended Breast Questionnaire

Have you ever been diagnosed with breast cancer? Yes _____ No_____

Type of Cancer	***Date of Dx***	***Presently Being Treated***
Metastatic	Mo Yr	
Local	Mo Yr	
Lymph node involvement	Mo Yr	

Where on the breast *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO
Right Breast	UO	UI	LI	LO
Treatment	Surgery _____	Chemo _____	Radiation ___	None _____

Diagnosed with breast disease: Yes____ No____ *If yes, please check* ***Type of Disease*** *below:*

Fibrocystic ___	Cystic _____	Mastitis _____	Abscess _____	Other_______

Breast biopsies or surgery *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO	Nipple
Right Breast	UO	UI	LI	LO	Nipple

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.

Breast Thermography Confidential Questionnaire

Please answer all questions	***Yes***	***No***
1. Do you have any close relative who has had breast cancer? Whom? ____		
Have you ever been diagnosed with breast cancer?		
Have you ever been diagnosed with any other breast disease (fibrocystic)?		
Have you had any biopsies or surgeries to your breasts?		
Have you had any breast cosmetic surgery or implants?		
Have you had a mammogram in the past 12 months?		
Have you had a mammogram in the past 5 years?		
Have you had abnormal results from any breast testing?		
1. Have you ever taken a contraceptive pill for more than 1 year? If yes, are you still taking a contraceptive pill? _______________		
Have you suffered with cancer of the womb?		
Have you had pharmaceutical hormone replacement therapy?		

1. Do you have an annual physical examination by a doctor? Does this include a gynecological exam?_______________________		
Do you perform a monthly breast self-exam?		

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 the birth of your first child? ________
17. Did your periods start before the age of 12? ______; Or finish after the age of 50? ________
18. Smoker status? ○ Yes ○ Never ○ Not in last 12 months ○ Not in last 5 years

Have you recently had any of these breast symptoms?	***Right Breast***	***Left Breast***
Pain		
Does pain subside after menstrual cycle ends		
Tenderness		
Does tenderness subside after menstrual cycle ends		
Lumps		
Change in breast size		
Does change in breast size subside after menstrual cycle ends		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Have you had any cosmetic fillers (i.e.: Botox, Restalyn, etc.) in the past 12 months?:
○ Yes ○ Never ○ Not in last 12 months

Have you ever had a thermographic scan? ○ Yes ○ Never ○ Not in last 12 months
If yes, please tell us when and with whom. There is a possibility we can access your past report for comparison.

____
____
____
____
____

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.

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

Patient Signature ____ Today's date _____________

Authorization to Use or Disclose Protected Health Information

Patient Name: ____

Address: ____

Date of Birth: __________________________ Date of Request: ______________________

As required by the Privacy Regulations, Thermography Rio Grande Valley, LLC, may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of (*describe in detail*): **Interpretation of said images**

Effective dates for this authorization (today's date) _____/_____/_____ .This authorization will expire at the end of 10 days. _____/____/____/.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance in the use or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient's Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected patient health information.

____ ________________

Signature of Patient or Patient's Authorized Representative *Date*

____ ________________

Authorized Signature of Facility *Date*