

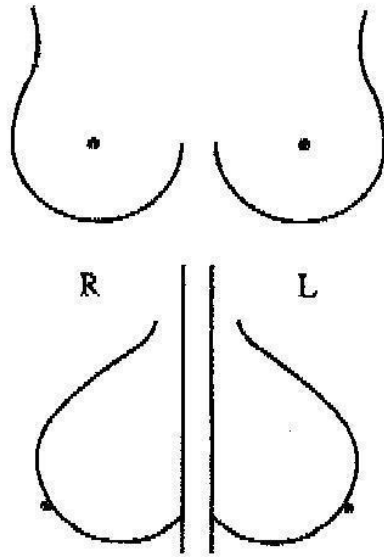
Name: _____ Birthdate: ____/____/____

Breast Study Questionnaire

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.

Please indicate below the following symptoms and mark where any of these are occurring:

- | | |
|--------------|---------------------------------------|
| -Breast Pain | -Areas of skin thickening or dimpling |
| -Lumps | -Change in breast size |
| -Redness | -Tenderness |
| -Swelling | -Secretions of nipples |
| -Warmth | -Skin Discoloration |



_____ **SIGN I do not have** breast pain, lumps, tenderness, swelling, warmth, redness, skin discoloration, areas of skin thickening or dimpling, change in breast size or secretions of the nipple.

_____ **SIGN I have** breast pain, lumps, tenderness, swelling, warmth, redness, skin discoloration, areas of skin thickening or dimpling, change in breast size or secretions of the nipple located in the following areas:

Date first noticed: ____/____/____

Describe: _____

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 illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic finding discussed in the Report. By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature: _____

Today's Date: ____/____/____