THE THERMOGRAPHY CENTER OF OREGON

Name: _____ **Birthdate:**_____

Address:_____ **City** _____ **Zip:**_____

Email: _____ **Phone:**_____ **Doctor:**_____

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 Questionnaire

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
5. Have you had any breast cosmetic surgery or implants?	☐	☐
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you suffered with cancer of the womb/uterus?	☐	☐
11. Have you had pharmaceutical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. 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 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: ☐ **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	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

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.

Signature …….. Today's date _____

Dr. Kelley R. Reis ● 172 SE 6th Ave Hillsboro, OR 97123 ● 503-693-0904

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THE THERMOGRAPHY CENTER OF OREGON

Extended Breast Questionnaire

Patient Name: _____ Date:_____

Diagnosed with breast cancer?

Cancer type: Metastatic___ Local___ Lymph node involvement___
When diagnosed: Month_____ Year_____
Where (left breast): UO____ UI____ LO____ LI____ Nipple____
Where (right breast): UO____ UI____ LO____ LI____ Nipple____
Treatment: Surgery____ Chemo____ Radiation____ Other____ None____

Diagnosed with other breast disease?:

Disease type: Fibrocystic____ Cystic____ Mastitis____ Abscess____ Other ____
(please report other types of disease in the history)

Breast biopsies or surgery?:

Where (left breast): UO____ UI____ LO____ LI____ Nipple____
Where (right breast): UO____ UI____ LO____ LI____ Nipple____

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Authorization to Use or Disclose Protected Health Information

THE THERMOGRAPHY CENTER OF OREGON

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *The Thermography Center of Oregon* 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: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

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

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

_____ _____
Authorized Signature of Facility *Date*