



Naturopathic Family Clinic  
*healing the whole person*

## Breast Thermography Intake Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary MD: \_\_\_\_\_

Reason for the exam/clinical concerns: \_\_\_\_\_

Current Symptoms: \_\_\_\_\_

Current Diagnoses: \_\_\_\_\_

Current treatments: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant past medical history: \_\_\_\_\_

Surgical History: \_\_\_\_\_

OB/GYN History: \_\_\_\_\_

Dental History: \_\_\_\_\_

Family history: \_\_\_\_\_

Do you have a close relative who has had breast cancer? \_\_\_\_\_ Please list: \_\_\_\_\_

Have you ever been diagnosed with breast cancer? \_\_\_\_\_ Date and type: \_\_\_\_\_

Have you ever been diagnosed with and other breast disease(fibrocystic)? \_\_\_\_\_

Have you had any biopsies or surgeries to your breasts? \_\_\_\_\_

Have you had 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? \_\_\_\_\_

How many mammograms have you had in total? \_\_\_\_\_ Age of first mammogram \_\_\_\_\_

How many thermograms have you had in total? \_\_\_\_\_

Have you had abnormal results from any breast testing? \_\_\_\_\_

Have you had ovarian or uterine cancer? \_\_\_\_\_

Have you had any type of cancer? \_\_\_\_\_

Have you ever taken a contraceptive pill for more than one year? \_\_\_\_\_

Have you taken hormone replacement therapy? \_\_\_\_\_

Do you have annual physical exams? \_\_\_\_\_

Are you currently a smoker? \_\_\_\_\_ If yes, how may packs per day? \_\_\_\_\_

Have you ever smoked? \_\_\_\_\_ When did you quit? \_\_\_\_\_

How may children have you had? \_\_\_\_\_ How old were you when you first child was born? \_\_\_\_\_

Did your period start prior to age 12? \_\_\_\_\_ Menopause finished after age 50? \_\_\_\_\_

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Have you recently had any of these breast symptoms:	Right	Left
Pain	___	___
Tenderness to touch	___	___
Lumps	___	___
Change in breast size	___	___
Skin thickening or dimpling	___	___
Secretions from the nipple	___	___

Do you have any skin lesions, tattoos or physical abnormalities that may affect the thermal images? \_\_\_\_\_

Other things we should know/notes for the thermographer: \_\_\_\_\_

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: \_\_\_\_\_ Date \_\_\_\_\_