BREAST THERMOGRAPHY CONFIDENTIAL QUESTIONNAIRE

Aberdeen Chiropractic Clinic
your health & well being since 1979

Date: Practitioner: Service Type: Patient ID:

Name: Age: Date of Birth:

Address: Town: Postcode:

Tel: (Home): Tel: (Work) Mobile:

Email:

Who recommended us to you?

Have you had a Thermoscan before? ☐ Yes ☐ No Date if applicable

1.	Do you have any relatives who have had breast cancer?	☐ Yes	☐ No
2.	Have you ever been diagnosed with breast cancer?	☐ Yes	☐ No
3.	Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐ Yes	☐ No
4.	Have you had any biopsies or surgeries to your breasts?	☐ Yes	☐ No
5.	Have you had any breast cosmetic surgery or implants?	☐ Yes	☐ No
6.	Have you had a mammogram in the past 12 months?	☐ Yes	☐ No
7.	Have you had a mammogram in the last 5 years?	☐ Yes	☐ No
8.	Have you had abnormal results from any breast testing?	☐ Yes	☐ No
9.	Have you ever taken a contraceptive pill for more than 1 year?	☐ Yes	☐ No
10.	Have you suffered with cancer of the womb?	☐ Yes	☐ No
11.	Have you had pharmaceutical hormone replacement therapy?	☐ Yes	☐ No
12.	Do you have an annual physical examination by a doctor?	☐ Yes	☐ No
13.	Do you perform a monthly breast self exam?	☐ Yes	☐ No
14.	Did your periods start before the age of 12?	☐ Yes	☐ No
15.	Did your periods finish after the age of 50?	☐ Yes	☐ No

16. How many mammograms have you had in total?

17. What was your age when you had your first mammogram?

18. How many births have you had? Your age at birth of first child?

19. Do you smoke? ☐ Yes ☐ Never ☐ Not in last 12 months ☐ Not in last 5 years

20. Have you recently had any of these breast symptoms? ☐ Yes ☐ No

	R	L		R	L
Pain Right or Left Breast	☐	☐	Tenderness	☐	☐
Lumps Right or Left Breast	☐	☐	Change in Breast Size	☐	☐
Areas of Skin Thickening or Dimpling	☐	☐	Secretions of the Nipple	☐	☐

EXTENDED BREAST QUESTIONNAIRE

DIAGNOSED WITH BREAST CANCER

Cancer Type Metastatic _____ Local _____ Lymph Node Involvement _____

When Diagnosed Month _____ Year _____

Where (Left Breast) Upper Outer ☐ Upper Inner ☐ Lower Outer ☐ Lower Inner ☐ Nipple ☐

Where (Right Breast) Upper Outer ☐ Upper Inner ☐ Lower Outer ☐ Lower Inner ☐ 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 _____

BREAST BIOPSIES OR SURGERY

Where (Left Breast) Upper Outer ☐ Upper Inner ☐ Lower Outer ☐ Lower Inner ☐ Nipple ☐

Where (Right Breast) Upper Outer ☐ Upper Inner ☐ Lower Outer ☐ Lower Inner ☐ Nipple ☐

Consent & Patient Disclosure

I understand that the report generated from my image 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 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 I understand the statements above and consent to the examination.

Signature: _____ Today's Date: _____