

Confidential Questionnaire

Men's Health Screening Body

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ (cellular) _____ (work) _____

E-Mail Address _____

Referring Physician _____

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.

Yes No

Head & Neck

- | | | |
|---|-----------------------|-----------------------|
| 1. Do you suffer with headaches?
If yes, <input type="radio"/> once a month or less <input type="radio"/> more than once a month | <input type="radio"/> | <input type="radio"/> |
| 2. Do you have allergies? Food _____ Environmental _____ | <input type="radio"/> | <input type="radio"/> |
| 3. Do you have TMJ or does your jaw click? | <input type="radio"/> | <input type="radio"/> |
| 4. Do you currently have a cold? | <input type="radio"/> | <input type="radio"/> |
| 5. Are you being treated for a thyroid disorder? Type _____ | <input type="radio"/> | <input type="radio"/> |
| 6. Do you have neck pain? | <input type="radio"/> | <input type="radio"/> |
| 7. Do you have upper back pain? | <input type="radio"/> | <input type="radio"/> |
| 8. Do you have a history of carotid artery disease? | <input type="radio"/> | <input type="radio"/> |
| 9. Do you have a family history of stroke? | <input type="radio"/> | <input type="radio"/> |
| 10. Do you currently suffer with sinus problems? | <input type="radio"/> | <input type="radio"/> |
| 11. Do you have history of dental problems?
Root canals ____ Gum disease ____ Implants ____

Non-replaced extractions ____ Dentures ____ | <input type="radio"/> | <input type="radio"/> |
| 12. Have you had dental cleaning in the past 7 days? | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Have you been diagnosed with: | | |
| Heart disease? | <input type="radio"/> | <input type="radio"/> |
| Lung disease? | <input type="radio"/> | <input type="radio"/> |
| Upper spine disorders? | <input type="radio"/> | <input type="radio"/> |
| 2. Do you suffer with upper back pain? | <input type="radio"/> | <input type="radio"/> |
| 3. Do you suffer with chest pain? | <input type="radio"/> | <input type="radio"/> |
| 4. Have you ever had surgery to your: | | |
| Heart? | <input type="radio"/> | <input type="radio"/> |
| Lungs? | <input type="radio"/> | <input type="radio"/> |
| Mid to upper back? | <input type="radio"/> | <input type="radio"/> |
| 5. Do you have asthma or shortness of breath? | <input type="radio"/> | <input type="radio"/> |
| 6. Do you currently smoke? | <input type="radio"/> | <input type="radio"/> |
| 7. Have you smoked in the past 5 years? | <input type="radio"/> | <input type="radio"/> |

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer with acid reflux or other digestive problems?	<input type="radio"/>	<input type="radio"/>	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	<input type="radio"/>	<input type="radio"/>
Stomach?	<input type="radio"/>	<input type="radio"/>	Spleen(Upper Left) ?	<input type="radio"/>	<input type="radio"/>
Below R Breast?	<input type="radio"/>	<input type="radio"/>	Liver(Upper Right) ?	<input type="radio"/>	<input type="radio"/>
Below L Breast?	<input type="radio"/>	<input type="radio"/>	Kidneys ?	<input type="radio"/>	<input type="radio"/>
Abdomen?	<input type="radio"/>	<input type="radio"/>	Intestines ?	<input type="radio"/>	<input type="radio"/>
Lower Back?	<input type="radio"/>	<input type="radio"/>	Abdomen ?	<input type="radio"/>	<input type="radio"/>
Pelvic Region?	<input type="radio"/>	<input type="radio"/>	Lower Back?	<input type="radio"/>	<input type="radio"/>
			Pelvic Region?	<input type="radio"/>	<input type="radio"/>

Have you consumed alcohol in the past 24 hours?

Do you have any special concerns or are there any details related to the information above?

Procedure: You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.

Patient Disclosure: I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination.

Patient Signature _____ Today's Date _____