Imaging Center _____

Breast Health History

Name:_____ Age:_____ Date Of Exam: _____

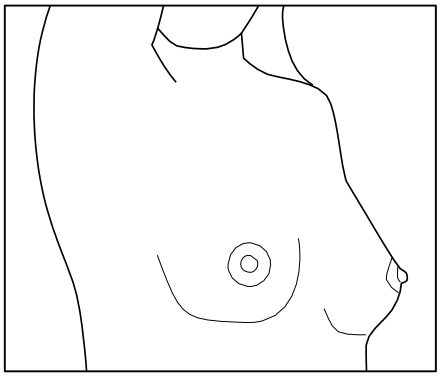
Date of Birth:_____ Sex: F ☐ M ☐ Initial Exam ☐ Follow-up Exam ☐

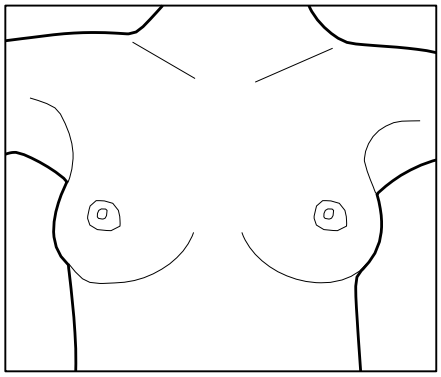
Describe any current breast concerns such as lumps, pain, skin changes or other concerns:

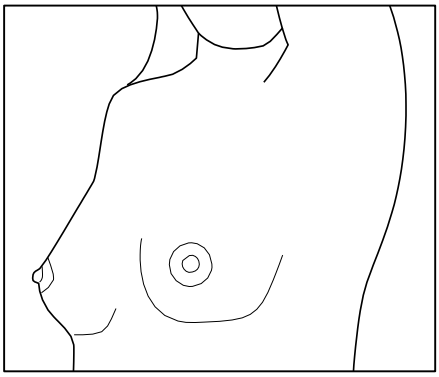
_____

_____

MARK THE AREA OF ANY CURRENT CONCERN ON THE DIAGRAM:







_____ _____ _____

_____ _____ _____

_____ _____ _____

Last Physical Breast Examination: Date _____

Results: ☐ Normal ☐ Other_____

_____

Mammogram: Date _____

Results: ☐ Normal ☐ Other_____

_____

Ultrasound: Date:_____ ☐ Left ☐ Right ☐ Both ☐ Normal ☐ Other _____

_____

MRI: Date:_____ ☐ Normal ☐ Other _____

_____

Biopsy: Date:_____ ☐ Left ☐ Right ☐ Both ☐ Normal ☐ Other_____

_____

COMPLETE ALL THAT APPLY:

Section 1: Breast Cancer

Diagnosed with breast cancer: Date of diagnosis _____ ☐ Left ☐ Right

Cancer Treatment:

☐ Lumpectomy: Date: _____ ☐ Mastectomy: Date: _____

☐ Reconstruction: Date: _____ ☐ Radiation treatment: Date of last treatment _____

Other treatment _____

Section 2: General

Benign Breast Surgery: Lumpectomy Date:_____ ☐ Right ☐ Left

Implants: Date:_____ Reduction: Date:_____

Fibrocystic breasts ☐ Y ☐ N, Cystic breasts ☐ Y ☐ N, Other breast conditions: _____

_____

Are you engaged in any lifestyle activities or diet designed to promote breast health, reduce inflammation or promote hormonal balance ☐ Yes ☐ No

Other medications: List types:_____

Currently Breast feeding: ☐ Y ☐ N

Pregnant: If not, current cycle day (# of days since 1st day of period):_____

Menopause: Experiencing symptoms of menopause or perimenopause: ☐ Y ☐ N

Age of last menses, if it has stopped:_____

Both (not one) ovaries removed: ☐ Y ☐ N

Family history of breast cancer: ☐ Y ☐ N

Past injury to the breasts: ☐ Yes ☐ No ☐ Left ☐ Right

Section 3: Hormones

Estrogen Based Birth Control: Duration:_____ Currently taking: ☐ Y ☐ N

Current Prescriptions Hormones:

☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ Thyroid hormone

Prior Prescription Hormones

☐ Estrogen ☐ Progesterone ☐ Testosterone ☐ Thyroid hormone

Non Prescription Cream or supplement to support the following:

☐ Estrogen ☐ Progesterone ☐ Thyroid ☐ Inflammation ☐ Other:_____

PLEASE DO NOT WRITE IN THIS SECTION

Tech: _____ Patient Temp: _____F Laboratory Temp: _____C

OFFICE USE ONLY

INFORMED CONSENT FOR TESTING PROCEDURE

Thermal Breast Imaging (otherwise known as breast thermography) detects and visualizes the thermal emissions (temperature) occurring at the surface of the breasts. The purpose of the examination is to detect signs of inflammation or unusual blood vessel activity that could suggest risk for current and/or future risk for cancer. Initial ____

I understand that Thermal Breast Imaging is used only as an adjunct to primary screening examinations such as physical breast examination, mammography, breast ultrasound and breast MRI and does not replace any other breast examination or screening. I also understand that thermal imaging does not and cannot directly detect or be used to diagnose breast cancer. Nor can it rule out the presence of breast cancer since some cancers do not produce sufficient temperature changes at the surface of the breasts to be seen with thermography. Therefore, breast cancer may still be present despite thermal imaging revealing a low risk. For that reason, thermal imaging does not replace any other breast examination. All breast concerns including but not limited to skin changes, nipple discharge, lumps or other abnormalities, clinical findings and radiographic findings require evaluation by a medical doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing cancer to be detected. Initial ____

I confirm that I have followed the written pre-examination protocols for breast imaging provided to me before the examination. I understand that if I did not receive or follow these protocols, the accuracy of my examination may be compromised. Initial ____

By signing below, I hereby acknowledge that (1) I have read and understood each of the above paragraphs; (2) I have had an opportunity to ask any questions I may have had; (3) any questions I asked were answered to my satisfaction; (4) I have received all the information I desire with respect to thermal imaging; (5) I understand no guarantee or warranty is being made that all risk for current and/or future cancer will be detected; and (6) I hereby authorize and consent to thermal imaging

_____ _____ _____

Print Name Signature Date

STATEMENT OF INDEPENDENT OPERATIONS:

I understand that Kane Thermal Imaging Interpretive Services is a California based company that contracts with the provider of your imaging services solely for the purpose of rendering interpretation and reporting of thermal imaging exams. This provider is not an employee, servant or agent of Kane Thermal Imaging Services. Nor is Kane Thermal Imaging Services an employee, servant, or agent of your provider. Kane Thermal Imaging Services and your provider are not in partnership or joint enterprise of any kind; but are separate business entities. Kane Thermal Imaging Services is an independent contractor hired by your provider to interpret your thermal imaging and report on the results. They are separate entities. Kane Thermal Imaging is not responsible for operations, advertising or any other aspect of your providers business other than the content of the thermal imaging report and its accompanying report guide.

_____ _____ _____

Print Name Signature Date