Please print out your completed form & bring it with you to your appointment

Initial Breast Health History

InfraMed

Name: _____

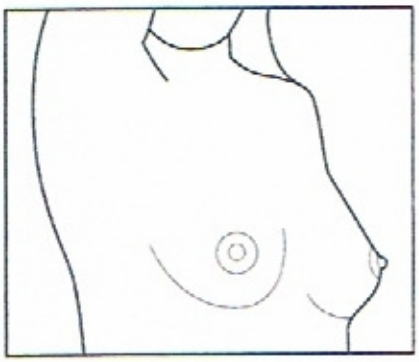
Address: _____

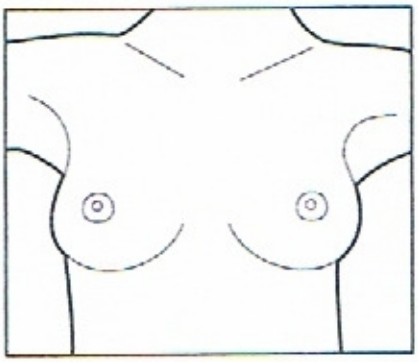
Phone: _____ Email: _____

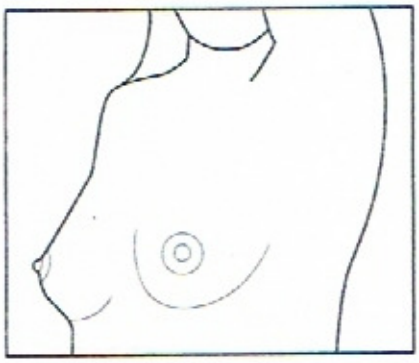
Date of Birth: _____ Sex: ☐ F ☐ M

MARK THE AREA OF ANY NEW CONCERN ON THE DIAGRAM:

1 LUMP
2 TUMOR
3 ITCHING
4 SURGICAL INCISION
5 PAIN
6 SCAR







Last Physical Breast Examination: Date _____

Results: ☐ Normal ☐ Other _____

_____

Mammogram: Date _____

Results: ☐ Normal ☐ Other _____

_____

Other Breast Tests (Ultrasound, MRI or Biopsy etc.) List test, date and results _____

_____

_____

COMPLETE ALL THAT APPLY:

☐ Diagnosed with breast cancer: Date of diagnosis _____

Location of cancer and type, if known _____

_____

☐ Lumpectomy ☐ Mastectomy ☐ Reconstruction: Date and details of procedure:

_____

_____

☐ Radiation treatment: Date last performed: _____

☐ Chemotherapy: Since: _____

☐ Other treatment _____

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

_____

☐ Breast surgery other than for cancer (benign lumpectomy, implants, reductions, etc.).

Date and procedure: _____

☐ Past injury to the breasts: Provide date, description and location _____

_____

☐ Birth control pills use: Duration: _____ Currently taking: ☐ Y ☐ N

☐ Prescription hormone replacement use including bioidentical:

Duration: _____ Currently taking: ☐ Y ☐ N

List types: _____

_____

☐ Non-prescription hormonal cream use and/or supplements to balance female hormones or thyroid.

Currently taking: ☐ Y ☐ N

List types: _____

☐ Other medications: List types: _____

_____

☐ Breast feeding: Currently ☐ Y ☐ N, Number of children nursed for over 1 month: _____

☐ 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, Age (or ages) of removal: _____

☐ Family history of breast cancer: List family member(s): _____

_____

Doctor in charge of your breast health:

Name: _____

Address: _____

Referral? ☐ Y ☐ N Phone: _____

Do you want us to send your doctor a copy of this report? ☐ Y ☐ N

CONSENT FOR TESTING PROCEDURE

Thermal Imaging of the breasts (otherwise known as breast thermography) measures surface temperature and provides information which may be used to help determine current and/or future risk for breast disease. Thermography can not diagnose breast cancer or rule out its presence. Some cancers do not produce sufficient temperature changes at the surface of the breasts to be seen with thermography. It does not replace mammography or any other breast examination. Thermal Imaging has no known risks or side effects associated with its use. ***Initial*** _____

I authorize this clinic's personnel to perform this thermal imaging examination and to send the images to **Robert L. Kane, DC, DABCT** for interpretation. ***Initial*** _____

I have read and complied with the pre-examination instructions for proper thermal imaging. ***Initial*** _____

Print Name: _____ Signature: _____

Date: _____

PLEASE DO NOT WRITE IN THIS SECTION

Tech: _____ Patient Temp: _____ C Laboratory Temp: _____ C

Patient ID No.: _____ Date of Examination: _____

OFFICE USE ONLY