

Initial Breast Health History

Name: _____ Age: _____ Date: _____

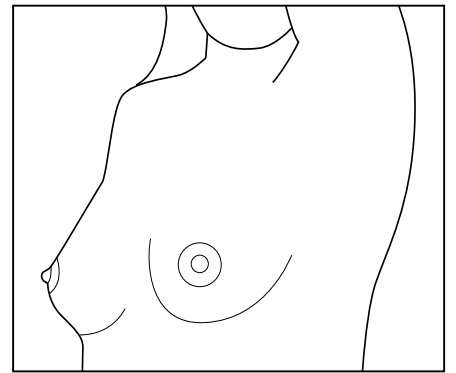
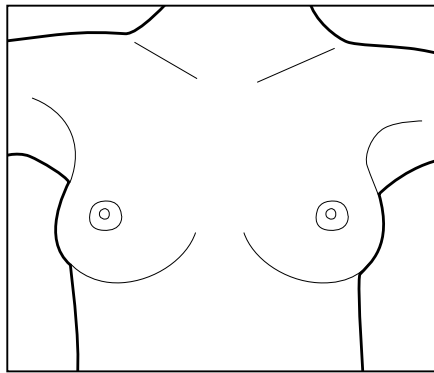
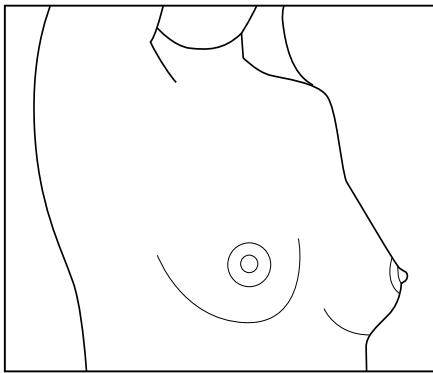
Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Date of Birth: _____ Sex: F M

Describe any current breast concerns such as lumps, pain, or abnormal examination findings:

MARK THE AREA OF ANY NEW CONCERN ON THE DIAGRAM:



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: _____

Zip: _____ Phone: _____

May we send your doctor the 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: _____ F Laboratory Temp: _____ C

OFFICE USE ONLY
