

# Follow up Breast Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  F  M

### PURPOSE OF THE EXAMINATION:

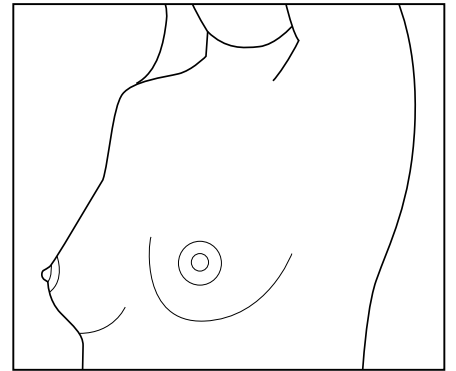
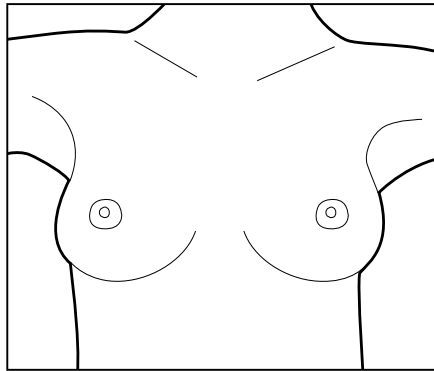
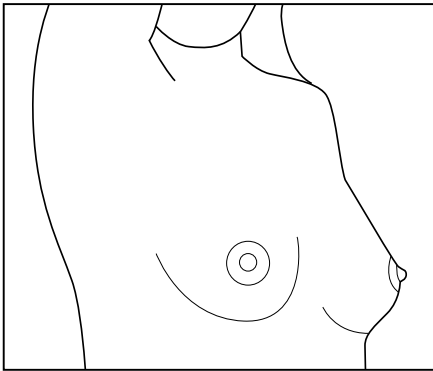
- Annual examination to assess breast health.
- Follow up to a prior thermogram that detected a sign of elevated risk or breast hormonal activity
- Follow up to help monitor a lump or other clinical finding found on another test

\_\_\_\_\_  
\_\_\_\_\_

- Evaluate a new breast concern

\_\_\_\_\_  
\_\_\_\_\_

### MARK THE AREA OF ANY NEW CONCERN ON THE DIAGRAM:



\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any new breast examinations since your last thermogram?  Y  N

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

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- Have you started or changed any doctor supervised treatment for breast health or hormonal balance since your last thermography examination including birth control pills?  Y  N

Describe: \_\_\_\_\_

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- Have you started or changed any home treatment (lifestyle modification, diet, supplements) for breast health or hormonal balance since your last thermography examination?  Y  N

Please describe: \_\_\_\_\_

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- New injury to the breasts: Provide date, description and location

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- Have you begun taking any other medications since your last examination?

Please list: \_\_\_\_\_

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- Have you begun breast feeding since your last examination?  Y  N

- Have you become pregnant since your last examination?

Y  N If not, current cycle day (# of days since 1st day of period) \_\_\_\_\_

- Have you begun experiencing symptoms of menopause since your last examination?  Y  N

Age of last menses if it has stopped since last examination: \_\_\_\_\_

- Have both ovaries been removed since your last examination?  Y  N

- Has a family member developed breast cancer since your last examination?

Y  N Who? \_\_\_\_\_

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

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**OFFICE USE ONLY**

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