Thermography Center of Montana

Patient Intake Form

For office use only:

Patient ID#_____ Next Appt._____

Report Ref #_____ BR1 BR2 BRA HB FB ROI

Referred by_____

Location_____ Scans uploaded_____

Data updated_____ called_____ Inv. Emailed____

Pt rpt sent_____ HCP rpt sent_____

Pymnt_____ ck #_____ V MC DISC #_____

Send report Via: CD____Print___Encypted Email___

Name _____

DOB _____ Age _____

Street _____

Town _____

State, Zip _____

Occupation _____

E-mail _____

Phones (Home) _____(Work)_____

(Cell) _____May we leave a message?○Y○N (Best No.)

Reason for today's visit: _____

_____

Symptoms: _____

_____

Current Treatment: _____

Current Medication: _____

HEALTH HISTORY

Mammo History: _____

Illnesses/Dates: _____

_____

Surgeries/Dates: _____

Injuries/Dates: _____

Do you want your report sent to your Health Care Provider? (circle one)○Yes ○No

Providers name and address: _____

_____

This information is confidential. All information is correct to my knowledge.

Signed: _____ Date: _____

Thermography Center of Montana

Authorization to Use or Disclose Protected Health Information

Thermography Center of Montana

Patient Name: _____

Address: _____

Date of Birth: _____ Date Request: _____

As required by the Privacy Regulations, *Thermography Center of Montana,* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations, Inc.

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

Effective date for this authorization: _____

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature or Patient or Patient's Authorized Representative *Date*

_____ _____

Authorized Signature of Facility *Date*

Thermography Center of Montana

INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- Thermography Center of Montana and its staff of certified thermographers will use Digital Infrared Thermal Imaging (DITI) to take images of specified region(s) of my body as requested.
- These images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
- My images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) Inc. (thermology group). The Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.
- DITI is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
- The Report will not tell me whether I have any illness, disease or condition, but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.
- DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI).
- I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore I hold Thermography Center of Montana harmless as to the results and interpretations resulting from this process.
- Thermography Center of Montana will keep all information shared by me completely confidential unless I provide a release in writing or as required by law (HIPAA).

Acknowledgement

By signing below I certify that I have read and understand the statements above and consent to the examination.

_____

Name (please print) Date Date of Birth

_____

Client Signature

_____Name, if other than client, and relationship to client

Thermography Center of Montana

Breast Thermography Confidential Questionnaire

Name:_____ DOB: _____

1. Do you have any close relative who has had breast cancer? Yes ◯ No ◯
2. Have you ever been diagnosed with breast cancer? Yes ◯ No ◯
3. Have you ever been diagnosed with any other breast disease (fibrocystic)? Yes ◯ No ◯
4. Have you had any biopsies or surgeries to your breasts? Yes ◯ No ◯
5. Have you had any breast cosmetic surgery or implants? Yes ◯ No ◯
6. Have you had a mammogram in the past 12 months? Yes ◯ No ◯
7. Have you had a mammogram in the past 5 years? Yes ◯ No ◯
8. Have you had abnormal results from any breast testing? Yes ◯ No ◯
9. Have you ever taken a contraceptive pill for more than 1 year? Yes ◯ No ◯
10. Have you suffered with cancer of the womb? Yes ◯ No ◯
11. Have you had pharmaceutical hormone replacement therapy? Yes ◯ No ◯
12. Do you have an annual physical examination by the doctor? Yes ◯ No ◯
13. Do you perform a monthly breast self exam? Yes ◯ No ◯
14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ Your age at birth of first child: _____
17. Did your periods start before the age of 12? _____ Or finish after the age of 50? ____
18. Do you smoke? Yes ◯ No ◯ Never ◯ Not in last 12 months ◯ Not in last 5 years ◯

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

Signature _____ Date _____

Thermography Center of Montana™

Extended Breast Questionnaire

Patient Name: _____Date:_____

Diagnosed with breast cancer:

Cancer type: Metastatic☐ Local☐ Lymph node involvement☐

When diagnosed: Month_____ Year_____

Where (left breast): UO☐ UI☐ LO☐ LI☐ Nipple☐

Where (right breast): UO☐ UI☐ LO☐ LI☐ Nipple☐

Treatment: Surgery☐ Chemo☐ Radiation☐ Other☐ None☐

Diagnosed with other breast disease:

Disease type: Fibrocystic☐ Cystic☐ Mastitis☐ Abscess☐ Other ☐

(please report other types of disease in the history)

Breast biopsies or surgery:

Where (left breast): UO☐ UI☐ LO☐ LI☐ Nipple☐

Where (right breast): UO☐ UI☐ LO☐ LI☐ Nipple☐

Thermography Center of Montana™

Patient Review of Body Systems

Name: _____DOB: _____ Date: _____

Constitutional

- ☐ Fevers/Chills/Sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/weakness
- ☐ Excessive thirst or urination

Musculo-Skeletal

- ☐ Muscle/Joint Pain

Ears/Nose/Throat

- ☐ Difficulty hearing/ringing
- ☐ Hay Fever/Allergies

Cardiovascular

- ☐ Chest Pain/Discomfort
- ☐ Leg Pain w/Exercise
- ☐ Palpitations

Other (please specify)

_____

_____

Dental

- ☐ Extractions
- ☐ Crowns
- ☐ Root Canal
- ☐ Gum Disease
- ☐ Fillings
- ☐ Other

Respiratory

- ☐ Cough/Wheeze
- ☐ Difficulty Breathing

Gastrointestinal

- ☐ Heartburn/Reflux
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Large bowel dysfunction
- ☐ Abdominal Pain

Genitourinary

- ☐ Kidney/Bladder
- ☐ Reproductive organs

Skin

- ☐ Rash or Mole

Neurological

- ☐ Numbness
- ☐ Headaches

Organ Dysfunction

- ☐ Liver/Gall Bladder
- ☐ Spleen/Pancreas

Blood/Lymphatic

- ☐ Unexplained Lumps
- ☐ Easy Bruising

General Medical History: Past and Current medical problems (please include dates)

- ☐ Heart Disease: (specify)
- ☐ Diabetes
- ☐ Asthma/Lung Disease
- ☐ Accidents
- ☐ Other: (specify)
- ☐ High Blood Pressure
- ☐ Thyroid Problem
- ☐ Chemical Exposure
- ☐ Injuries
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Cancer: (specify)

_____

_____

Family History: Please indicate the current status of your immediate family members (Mother, Father, Sibling, Grandparent, Aunt, Uncle)

- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Genetic Disorders
- ☐ Cancer: type _____
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Asthma/COPD
- ☐ Diabetes
- ☐ Bleeding or Clotting
- ☐ Other

Thermography Center of Montana

Full Body Questionnaire/Region of Interest/Special Interest

Name: _____ DOB:_____ Date:_____

Please use the symbols below to indicate areas of:

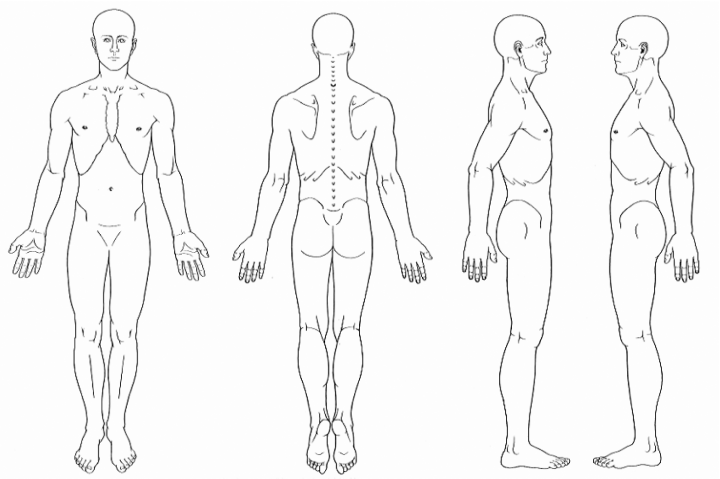
Main Pain *

Secondary Pain ❍

Numbness ////////

Pins and needles ::::::::

Skin lesions / scarring (mark location as they appear on your body)



Do you know what triggered the pain?

_____

_____

Does anything relieve it?

_____

_____

Does anything aggravate it?

_____

_____

Has it changed since it began?

_____

_____

Have you had any treatment?

_____

_____

Other comments:

_____

_____

_____

Signature_____

Print Reset