Tulsa Breast Center

Office Use Only

Payment: _____EMI #:_____

Report Ref. #_____

Email: ____Go:_____ Outlook:_____

Name: _____ D.O.B. _____ Age: _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: (cell) _____ (Home)_____

E-mail: _____ Occupation: _____

How did you find out about us? _____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

Tulsa Breast Center uses a Meditherm Digital Infrared Thermal Imaging camera to provide a 15 minute non-invasive test of physiology. DITI detects the minute physiologic changes that accompany breast pathology.

I understand that Tulsa Breast Center does not provide a medical diagnosis, but simply acts as the clinical Thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to Tulsa Breast Center. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider. A doctor to doctor consultation can be arranged between Meditherm and your doctor if necessary.

I give my permission for the Clinical Thermographer at Tulsa Breast Center to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that two sets of thermography pictures will be mailed to me so that I can share one with my health care practitioner or primary care doctor.

Client Signature_____ Date_____

Thermographer's Signature_____ Date_____

All Clinical Thermographers
are trained and certified by the ACCT.

Patient Name: _____ **DOB:** _____

Thermography is not recommended during the following conditions/treatments because it can affect the thermal activity; a **three-month waiting period** is advised.

Please indicate current condition/treatment		
Breastfeeding	○ Yes	○ No
Pregnancy	○ Yes	○ No
Radiation treatment	○ Yes	○ No
Chemotherapy	○ Yes	○ No
Surgery (screening area)	○ Yes	○ No

Primary Care Physician: _____

Referring Physician's Name: _____

Clinical Concerns and Current Symptoms

Medical Problem	*Date of Onset*	*Comments/Concerns/Symptoms*

Current Treatments (Including BHRT, Supplements, chiropractic, etc.)

Treatment	*Date started*	*Comments*

Current Medication:

Medication Name	*Taken For*	*Date Started*

Thermogram History: (Previous significant findings)

_____

_____

Results of any Clinical Correlation

_____

Surgery history:

Type of Surgery	*Year(s)*	*Comments*

Significant Dental Work: (Root canals, wisdom teeth, crowns, etc.)

Type of Work	*Year(s)*	*Location (i.e. upper right)*

General History: (*Previous significant illnesses or issues*)

Illness	*Year(s)*	*Comments*

Family History: (*As it relates to history of cancer and especially breast cancer*)

Relation	*Type*	*Comments*

Diagnoses:

Diagnoses	*Year(s)*	*Comments*

Skin lesions or other physical abnormalities:

Type	*Onset*	*Location*

Date of last MAMMOGRAM or ultrasound (IF in the last 12 months) _____

OB/GYN history:_____

_____

Patient Name: _____

Breast Thermography Confidential Questionnaire

Please answer all questions	*Yes*	*No*
1. Do you have any close relative who has had breast cancer? Whom? _____		
2. Have you ever been diagnosed with breast cancer?		
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?		
4. Have you had any biopsies or surgeries to your breasts? (Other than cosmetic surgery or implants)		
5. Have you had any breast cosmetic surgery or implants?		
6. Have you had a mammogram in the past 12 months?		
7. Have you had a mammogram in the past 5 years?		
8. Have you had abnormal results from any breast testing?		
9. Have you ever taken a contraceptive pill for more than 1 year? If yes, are you still taking a contraceptive pill? _____		
10. Have you suffered with cancer of the womb?		
11. Have you had pharmaceutical hormone replacement therapy?		
12. Do you have an annual physical breast examination by a doctor?		
13. Do you perform a monthly breast self-exam?		
14. Did your periods start before the age of 12?		
15. Did you periods finish after the age of 50?		

16. Have you had any vaccines in the last 4 weeks? (circle one) NO Right arm Left arm
17. How many mammograms have you had in total? _____
18. What was your age when you had your first mammogram? _____
19. How many births have you had? _____ **Your** age at the birth of your first child? _____
20. Smoker status? ○ Current ○ 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		
Does pain subside after menstrual cycle ends		
Tenderness		
Does tenderness subside after menstrual cycle ends		
Lumps		
Change in breast size		
Does change in breast size subside after menstrual cycle ends		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Extended Breast Questionnaire

Have you ever been diagnosed with breast cancer? Yes _____ No_____

Type of Cancer	***Date of Dx***	***Presently Being Treated***
Metastatic	Mo Yr	
Local	Mo Yr	
Lymph node involvement	Mo Yr	

Where on the breast *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO
Right Breast	UO	UI	LI	LO
Treatment	Surgery _____	Chemo _____	Radiation ___	None _____

Diagnosed with breast disease: Yes____ No____ *If yes, please check **Type of Disease** below:*

Fibrocystic ___	Cystic _____	Mastitis _____	Abscess _____	Other_____

Breast biopsies or surgery *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO	Nipple
Right Breast	UO	UI	LI	LO	Nipple

Please explain any past or current treatment for breast disease:_____
_____
_____

PATIENT DISCLOSURE

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. I also understand that the information provided by the thermographers is intended for educational purposes only and pertains to traditional and historical ideas on breast health and is not intended to treat, cure, or prevent any disease.

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

Patient Signature _____ Today's date _____

Authorization to Use or Disclose Protected Health Information

Tulsa Breast Thermography, LLC

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, ***Tulsa Breast Thermography, LLC*** **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

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of (*describe in detail*): **Interpretation of said images**

Effective dates for this authorization_____/_____/_____ through _____/_____/_____. This authorization will expire at the end of this period.

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

_____ _____

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

_____ _____

Authorized Signature of Facility *Date*