

KEEP COOL

THERMOGRAPHY



PREPARING FOR THERMAL IMAGING APPOINTMENT

Thank you for choosing **Keep Cool Thermography** as your source for thermal imaging and breast care. We look forward to meeting you and assisting you with this safe and effective procedure. It is important that you fill out these forms accurately and completely. Your scheduled appointment time takes into consideration that you have filled out your forms prior to the exam.

1. Please be at the office approximately 15 minutes before your appointment.
2. Make sure to bring this packet with you, filled out and complete (please PRINT).
3. DO NOT bring small children with you who cannot be left unattended.
4. Make sure you read and understand the informed consent form in this packet as it explains the procedure and your rights.
5. If you have ANY questions about your examination, call your testing center.
6. Please be prepared to pay for your examination at the time of your visit. Check, cash, and all major credit cards are accepted.

IMPORTANT PROTOCOLS

If you have a sunburn or fever, please call to reschedule.

24 hours prior to exam: avoid chiropractic care, physical therapy, massage therapy, acupuncture, saunas, steam baths, hot tubs, magnets, heating pads, hot water bottles, analgesic creams or balms, poultices, and do not shave.

12 hours prior to exam: do not stimulate the nipple in any way.

4 hours prior to exam: No coffee, tea, soda or other beverages or medications containing caffeine. No alcoholic beverages. Do not bathe or shower in HOT water. Do not perform any rigorous exercise program. Do not touch or rub any body part vigorously.

The day of the exam: do not use creams, lotions, ointments, deodorants, antiperspirants, powders or any other skin product. Do not smoke cigarettes or use any product which contains nicotine. Do not use any medication or natural supplement that causes flushing (i.e. Niacin).

Please wear jockstrap, G-string or bikini underwear to facilitate the examination.

Inform us if you have had chemotherapy or radiation treatment within the last 2 months.

Remove all piercings and jewelry prior to the exam. If your hair/bangs cover your forehead, bring a headband to hold it back away from the forehead. If you have long hair (touches the shoulders) bring a hairband to hold it off of the neck.

In preparation for your session, do not discontinue any medication or therapy without your doctor's permission.

Initial Breast Health History

Name: _____ Age: _____ Date: _____

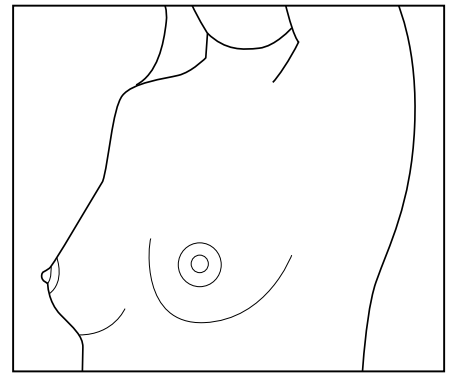
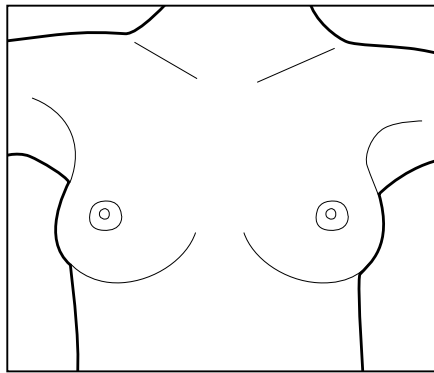
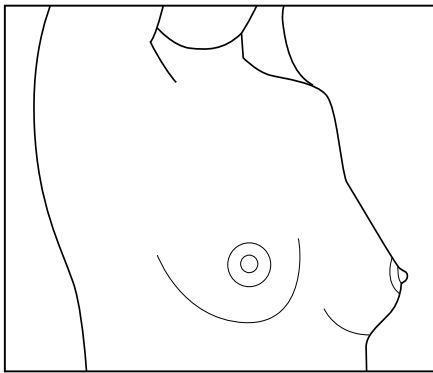
Address: _____ Email: _____

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): _____
