Patient Information

First Name ______________________________

( ) Male (•) Female

Last Name ______________________________

Mailing Address ______________________________

City ______________________________

State/Province ______________________ Zip______________

Birth Date ______________________________

Email Address ______________________________

Phone ______________________________

Lab Location ______________________________

Have you had thermography before? ______________________________

Which BTI Lab? ______________________________

Referred by ______________________________

How did you hear about us? ______________________________

Important Protocols

Patient is expected to thoroughly complete each field to the fullest extent. Upon review, the staff may return based on incomplete documentation. Interpretation will not be completed without adequate completion of this document.

Thermal imaging is a heat sensitive test. Anything which creates heat should be avoided prior to testing: excessive metabolic activity, friction, or any of the activities listed below which will alter heat readings. For the best results, please wear thong underwear or a jock strap for full body studies. Men with beards should shave their face and neck 48 hours prior to their appointment.

Thermal imaging is a heat sensitive test. Anything which creates heat should be avoided prior to testing. Excessive metabolic activity, friction, or any of the activities listed below will alter heat readings.

1 Month Prior:

- No minor breast surgery, i.e. biopsy
- We may still perform after biopsy. Write this in form

1 Week Prior:

- Be cautious of too much sun exposure in order to avoid sunburn. Scans will have to be rescheduled if the patient has a sunburn of any sort.

48 Hours Prior:

- Men with beards should shave their face and neck, as well as backs
- Avoid all tanning and limit sun exposure

24 Hours Prior:

- Avoid chiropractic care, massage therapy or acupuncture
- No saunas, steam baths, hot tubs, heating pads, or hot water bottles
- No analgesic creams or balms
- Do not shave underarms (Should be done prior)
- Reschedule if you experience a significant fever
- Refrain from sexual activity

Day of Exam:

- For best results, please wear thong underwear or a jock strap for full body studies. Underwear is optional and best results are without.
- Do not use creams, lotions, cosmetics, ointments, deodorant, antiperspirants, powders or any other skin product.
- Please bring a hair tie to remove hair from your forehead and back of neck
- Remove all piercings and jewelry prior to exam, unless unable to.

4 Hours Prior:

- Avoid hot showers or shaving
- Avoid physical therapy or exercise
- No coffee, tea, soda, or other beverages containing caffeine. No alcoholic beverages.
- Do not smoke cigarettes or use any product which contains nicotine
- Women – do not wear a bra for the 4 hours leading up to the exam

2 Hours Before the Exam:

- Avoid hot or cold liquids
- Avoid eating or chewing gum
- Avoid using a cell phone

Prior to and During Exam:

- Please inform us if you have a hot flash during the session
- Try to relax prior to and during the exam. Stress will affect your exam.

☐ *I have read the the protocols required for this method of screening and will adhere to the protocols beginning 24 hours prior to my exam.

MINDFUL WELLNESS
Medical Thermography

Breast & Chest 1

*Breast/Chest Concerns

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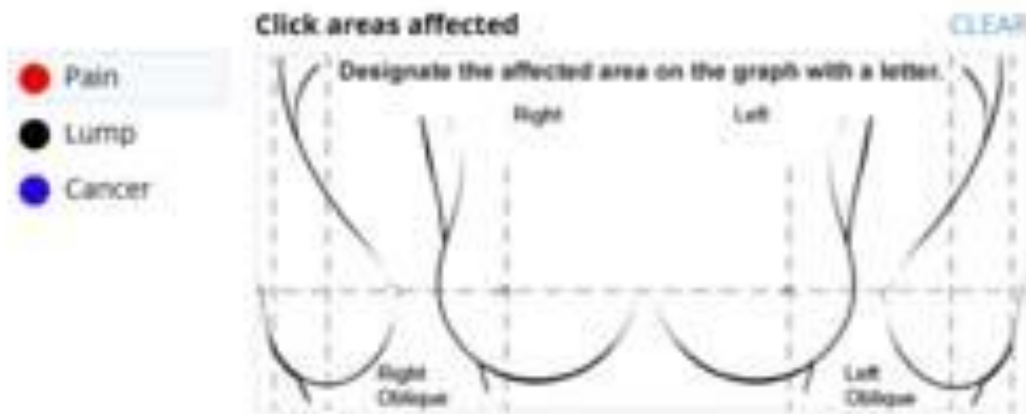
If you have a pending biopsy, note the proposed location (left or right breast, clock face numerical reference). If you have no concerns regarding this area, please enter "no concerns". (Include extra paper if additional information is needed.)

Recent Breast Symptoms: check all that apply

	Left	Right
Change in Breast Size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Excretions of the nipple	☐	☐

Click areas affected



8859 Cincinnati-Dayton Road • Suite #007 • West Chester, Ohio 45069
www.MindfulWellnessMedicalThermography.com
Phone: 1-877-315-7226 Ext. 452
Phone: 513-382-3132

Breast & Chest 2

How many mammograms have you had? ____

Date of last anatomical study (mammogram, MRI, ultrasound) ____________________________

What were the results of your Mammography? ____

Have you ever been diagnosed with breast cancer? ______________________________________

Date of diagnosis ____

If yes, what type? ____

Breast & Chest 3

What type of treatment did you receive?

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What kind of Hormone Therapy are you taking?

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If you have other breast disorders or procedures, please list type, location, date, treatment, and results (Include extra paper if additional information is needed.)

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Surgical History (Please list type, location, date, treatment, and results) (Include extra paper if additional information is needed.)

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General Medical History

Please check all that apply

- ☐ Hysterectomy
- ☐ Implants
- ☐ Contraceptive Pills
- ☐ Other Breast Disorders/Procedures
- ☐ Hormone Replacement Therapy
- ☐ Currently Breastfeeding

MINDFUL WELLNESS
Medical Thermography

Head & Neck

Please check all that apply

- ☐ Allergies
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Current Cold
- ☐ Bleeding Gums
- ☐ Recent Dental Work
- ☐ Dental Problems
- ☐ TMJ
- ☐ Thyroid Disorder
- ☐ Neck Pain
- ☐ Asthma
- ☐ Smoke
- ☐ Carotid Artery Disease
- ☐ Personal/Family History of Stroke

*Specific Concerns (Include extra paper if additional information is needed.)

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If you have no concerns regarding this area, please enter "no concerns."

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Abdomen & Spine

Please check all that apply

☐ Upper back pain ☐ Lower back pain ☐ Scoliosis ☐ Acid Reflux

Pain

☐ Stomach ☐ Right Chest ☐ Left Chest ☐ Pelvis ☐ Abdomen

Surgical History (Please list type, location, date, treatment, and results) (Include extra paper if additional information is needed.)

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*Specific Concerns

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If you have no concerns regarding this area, please enter "no concerns."

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Upper Extremities

Please check all that apply

- ☐ Left Shoulder
- ☐ Right Shoulder
- ☐ Left Elbow
- ☐ Right Elbow
- ☐ Left Arm
- ☐ Right Arm
- ☐ Right Hand
- ☐ Left Hand

Surgical History (Please list type, location, date, treatment, and results) (Include extra paper if additional information is needed.)

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*Specific Concerns (Include extra paper if additional information is needed.)

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If you have no concerns regarding this area, please enter "no concerns"____________________

Lower Extremities

Please check all that apply

- ☐ Left Hip
- ☐ Right Hip
- ☐ Left Leg
- ☐ Right Leg
- ☐ Left Knee
- ☐ Right Knee
- ☐ Left Ankle
- ☐ Right Ankle
- ☐ Left Foot
- ☐ Right Foot
- ☐ Sciatica

Surgical History (Please list type, location, date, treatment, and results) (Include extra paper if additional information is needed.)

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*Specific Concerns (Include extra paper if additional information is needed.)

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If you have no concerns regarding this area, please write "no concerns"____________________

HIPAA and Statement of Understanding

This analysis was performed by the request of this patient or a referring physician. It is an analysis of infrared heat mapping of the skin surface temperatures. The analyses performed are based on the interpreter's impressions without seeing the patient in person. Some of the findings may be due to artifacts or obvious benign issues that should be dismissed as pathology based on you clinical investigation. Relevant comments are made to direct the physician in clinical management. This important tool should be used in addition to the physician's other diagnostic tools to create a complete clinical impression. The areas highlighted represent areas of concern that may need to be investigated by clinical correlation and other testing. This may include physical, exam, palpation, radiology, metabolic testing, or other traditional methods of diagnosing. Thermographic imaging is a screening test that alerts of possible areas of pathology at the indicated levels. Normal variants are also common. Sometimes pathological findings appear earlier than tradition tests. Close thermal follow-up is highly recommended over time.

HIPAA Compliance and Informed Consent

This covered entity is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.

For Purposes of this notice, the term "covered entity" refers to Thermographic Wellness, LLC, Breast Thermography International, The Professional Academy of Clinical Thermology, the testing doctor, the interpreter, the testing facility, the technician(s), and any person involved in the proposed exam.

You have rights concerning your private health information, your access to this information and to know how this information is used by our office. You also have rights related to our ability to contact you concerning your activity in our practice, such as recall reminders, billing and other matters related to how we communicate with you and others on your behalf. Please understand that this office and each and all of its employees and associates make every effort possible to keep confidential your private medical information at all times and with your consent only, will such information ever be shared with others.

A. The covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to the individual.

B. Your information will not be shared with any third party without your express written consent. Your images will be interpreted by outside interpreters and consultants, and you hereby grant permission for this purpose. Files will be transferred by email, server upload, and other forms of electronic transfer. Files may be non-encrypted. Files may be relayed for second opinion to colleagues. Your information may be used for academic purposes, at which point no names, or other identifiable information will be demonstrated.

C. Your records are available to you for review, copying or corrections by appointment and you will not be denied access to your personal health information. Any changes you request to your personal health information must be supplied to this office in writing and you will be advised within 30 days of any objection to the correction, or that the correction has been made.

D. With respect to other providers requesting your personal health information, we will require a written authorization for the release of medical records signed by you, detailing the name, address, and phone number of the requesting physician. Under no circumstance will we discuss your personal health information with anyone.

You have rights concerning your private health information, your access to this information and to know how this information is used by our office. You also have rights related to our ability to contact you concerning your activity in our practice, such as recall reminders, billing and other matters related to how we communicate with you and others on your behalf. Please understand that this office and each and all of its employees and associates make every effort possible to keep confidential your private medical information at all times and with your consent only, will such information ever be shared with others.

*I agree to have my report sent to:

Full Name ____

Signature ____