Preparation Instructions for Thermography

Thermography is infrared photography and heat sensitive only.
NO CONTACT, NO PAIN, NO RADIATION

Your body must be as neutral as possible to insure valid results.

NOTIFY the staff if you had breast surgery, chemotherapy or radiation in the past 3 months, we may need to adjust your appointment for optimal results.	
5 days before	NO natural or artificial tanning of any areas to be imaged. Sunburn of the underarms, front of neck, chest or breast area could interfere with true exam results.
24 hours before	If you get a significant fever (over 101^0F), please call to reschedule.
	DO NOT shave areas to be imaged within 24 hours (under arms-etc.). DO NOT use a saunas or steam-rooms. DO NOT use hot/cold packs directly contacting the breasts.
	NO self or Clinical Breast examinations NO Acupuncture, Chiropractic or Physical Therapy. NO physical manipulation or compression of any areas to be examined. NO ultrasound therapy or use of TENS (electrical stimulation). NO Ultrasound, X-Ray, Mammograms, MRI, CT or PET scans

On The Day of Your Appointment

NO powders on your breasts or underarms. NO deodorants, skin creams, lotions, or perfumes. WEAR lose fitting garments prior to exam. REMOVE all jewelry specific to areas being imaged IF NURSING, please complete 30 minutes before the exam. DO NOT BRING babies or children to the office, as it will affect the outcome your exam.	
6 hours before exam	NO energy drinks or bars NO pain medications or aspirin. NOTIFY the staff if you have taken medications (blood pressure, alpha-blocker, circulation, anti-coagulants, aspirin or pain medication). CHECK with your doctor if changes to your schedule can be made.
2-3 hours before exam	DO NOT Shower or bathe less than 3 hours before your exam. NO food or beverages (room temperature water only). NO smoking, vaping, chewing tobacco, chewing gum or mints/candies.

We look forward to seeing you and providing your thermography services.

If you need to change your appointment, please call 323.662.2891, at least 48 hours before your scheduled appointment time as a courtesy to others and to avoid a missed appointment fee of $50 per instance.

Thermography Wellness Center

Health History (Breast)

Patient Name:				Appointment Date:	
Address:				Home Phone:	
City/State/Zip:	/	/		Cell Phone:	
SSN # *(ID#)*:	xxx-xx	Gender:	F / M	*Carrier (text messages)*	AT&T · Sprint · T-Mobile · Vrzn
Marital Status:		Spouse:		Email:	
Language:		Race:		Referred By:	
Date of Birth:		Age:		Primary Doctor:	

EXAM: Thermography w/TH score ☐ *Are you providing reports?*

☐ None — TWC Thermography — mo/yr: ___/___ TH
☐ 3-6 month — TWC Thermography — mo/yr: ___/___ TH
☐ 6-9 month — TWC Thermography — mo/yr: ___/___ TH
☐ Annual — _____ — mo/yr: ___/_____ normal/abnormal

OFFICE USE:
△ ☐ *Rush $57*
△ ☐ *super bill*
△ ☐ *paper*
$Charge *ck#* *| cc/$* ☐ *GFCA/CTA pt*

HISTORY: R/L = Right/Left n/a = normal/abnormal *(please circle what applies)*

☐ None
☐ *No changes*

Mammogram	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
Mammogram - 3D	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
R/L Breast Ultrasound	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
R/L Breast Biopsy (marker)	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
R/L Breast Sonogram	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
Breast MRI	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
Breast CT	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
Breast PET	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
Blood Test – Cancer Markers _____		mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
Salvia Test – Hormones_____		mo/yr: ___/____ n/a	mo/yr: ___/____ n/a
☐ _____		mo/yr: ___/____ n/a	mo/yr: ___/____ n/a

Notes:
☐ *Are you providing reports?*

PROCEDURES: R/L = Right/Left *(please circle what applies)*

☐ None
☐ *No changes*

R/L Implants	mo/yr: ___/____	R/L Reduction	mo/yr: ___/____
R/L Lift	mo/yr: ___/____	R/L Repair	mo/yr: ___/____
R/L Reconstruction	mo/yr: ___/____	R/L _____	mo/yr: ___/____

Results:
☐ *Are you providing reports?*

DIAGNOSIS/CONDITIONS: R/L = Right/Left *(please circle what applies)*

☐ None
☐ *No changes*

R/L Abscess	mo/yr: ___/____	R/L Fibro adenoma	mo/yr: ___/____
R/L Calcifications	mo/yr: ___/____	R/L Padget Disease	mo/yr: ___/____
R/L Cystic/ Fibrocystic	mo/yr: ___/____	R/L Scar Tissue	mo/yr: ___/____
R/L Dense Tissue	mo/yr: ___/____	R/L _____	mo/yr: ___/____

R/L Estrogen+/Progesterone+	mo/yr: ___/____	
R/L HER2 positive Breast Cancer	mo/yr: ___/____	
R/L IBC Inflammatory Breast Cancer	mo/yr: ___/____	
R/L Ductal Carcinoma/ DCIS (InSitu)	mo/yr: ___/____	
R/L Lobular Carcinoma/ LCIS (InSitu)	mo/yr: ___/____	
R/L Metastatic Breast Cancer	mo/yr: ___/____	
R/L Papillary Carcinoma	mo/yr: ___/____	
R/L Triple Negative Breast Cancer	mo/yr: ___/____	
R/L _____	mo/yr: ___/____	

Notes:
☐ *Are you providing reports?*

CANCER TREATMENT/SURGERIES: R/L = Right/Left *(please circle what applies)*

☐ None
☐ *No changes*

R/L CBD/RSO Therapy	mo/yr: ___/____	Cryo/Infrared Therapy	mo/yr: ___/____
R/L Natural Salve	mo/yr: ___/____	Iodine Therapy,	mo/yr: ___/____
R/L Ductal Lavage	mo/yr: ___/____	Immune Therapy	mo/yr: ___/____
R/L Laser	mo/yr: ___/____	Oxygen Therapy	mo/yr: ___/____
R/L Lumpectomy	mo/yr: ___/____	Nutrition/Supplements	mo/yr: ___/____
R/L Mastectomy	mo/yr: ___/____	Chemotherapy	mo/yr: ___/____
R/L Proton Radiation	mo/yr: ___/____	Hormone Drugs	mo/yr: ___/____
R/L Radiation	mo/yr: ___/____	Clinical Trial Drugs	mo/yr: ___/____
R/L _____	mo/yr: ___/____	_____	mo/yr: ___/____

Notes:
☐ *Are you providing reports?*

Patient Name: _____ DOB: _____ Appointment Date: _____

FAMILY HISTORY: Breast cancer in family? *(please circle what applies)*

☐ None ☐ *Unknown* ☐ *No changes*

Familial:	Mother	Father	Sister	Brother	☐ _____
Maternal:	Grandmother	Grandfather	Aunt	Uncle	Cousin
Paternal:	Grandmother	Grandfather	Aunt	Uncle	Cousin

Notes: ☐ HER2+ ☐ BRCA1 ☐ BRCA2

HORMONE REPLACEMENT: S/B/H =Synthetic Bio-Identical Herbs/Supplements *(please circle)*

☐ None ☐ *No changes*

S/B/H Thyroid | S/B/H Estrogen | S/B/H Progesterone | S/B/H Testosterone

S/B/H | S/B/H

Notes:

WOMEN: At what age did periods begin: __ Current Cycle, day #:___ *(please circle what applies)*

☐ None ☐ *No changes*

Currently pregnant: Age at 1st full term pregnancy ___ # pregnancies: ____

Pre-menopause at Age: _____ Menopause at Age_____

Ovaries removed at Age: _____ Hysterectomy at Age: _____

Notes:

BIRTH CONTROL: C/P = Currently Using /Previously Used *(please circle what applies)*

☐ None ☐ *No changes*

C/P Cervical Cap	C/P Injection	C/P Patch	C/P Sponge
C/P Diaphragm	C/P Implant	C/P Pill	C/P Sterilization
C/P Emergency	C/P Intrauterine Device	C/P Spermicide	C/P Vaginal Ring
C/P Female Condom	C/P Natural Planning	C/P	

How long used/using:

MEDICATIONS:

☐ None ☐ *No changes*

_____ _____

_____ _____

_____ _____

Notes:

SUPPLEMENTS/HERBS:

☐ None ☐ *No changes*

_____ _____

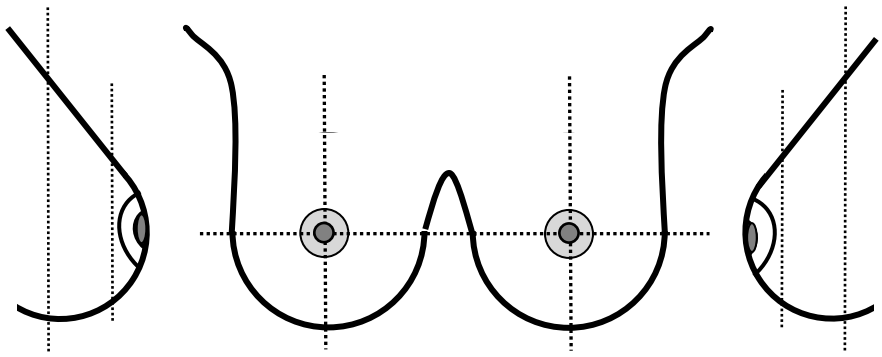
_____ _____

_____ _____

Notes:

Diagram your condition/symptoms; mark it with a dot, cross, circle or arrow as needed, use the symptom number and the letter code for frequency.
Present; Always - 100% Frequently-75% Intermittently - 50% Occasionally - 25% of time.

RIGHT BREAST	%	LEFT BREAST	%
☐ **NONE**		☐ **NONE**	
☐ **Historically larger**		☐ **Historically larger**	
1 *Infection*		1 *Infection*	
2 *Itching*		2 *Itching*	
3 *Lump- Lump w/ pain*		3 *Lump- Lump w/ pain*	
4 *Marker*		4 *Marker*	
5 *Nipple-tender*		5 *Nipple-tender*	
6 *Nipple-inverted*		6 *Nipple-inverted*	
7 *Pain dull*		7 *Pain dull*	
8 *Pain Sharp*		8 *Pain Sharp*	
9 *Pressure*		9 *Pressure*	
10 *Prickling*		10 *Prickling*	
11 *Skin-dimpling*		11 *Skin-dimpling*	
12 *Skin-discolored*		12 *Skin-discolored*	
13 *Skin-scaly*		13 *Skin-scaly*	
14 *Skin-reddening*		14 *Skin-reddening*	
15 *Swollen*		15 *Swollen*	
16 *Tenderness*		16 *Tenderness*	
17 *Nipple-discharge* [clear] [yellow] [brown] [bloody]	pre	17 *Nipple-discharge* [clear] [yellow] [brown] [bloody]	
18 *Breast size/shape recently changed: smaller/larger* _____		18 *Breast size/shape recently changed: smaller/larger* _____	
19 _____		19 _____	



Right Lateral RIGHT - BREAST - LEFT *Left Lateral*

INJURIES: Any breast/chest injuries throughout your life? *(please circle what applies)*

☐ None ☐ *No changes*

R/L Auto Accident	mo/yr: ____/____	R/L Piercing (s)	mo/yr: ____/____
R/L Chemical Exposure	mo/yr: ____/____	R/L Occupational	mo/yr: ____/____
R/L Sports/Hobbies	mo/yr: ____/____	R/L Tattoos	mo/yr: ____/____
R/L Parenting	mo/yr: ____/____	R/L	mo/yr: ____/____

Notes:

OFFICE USE:

Certified Clinical Thermologist
Dr. Claire H. O'Neill DC, FICCT, BCCT

CTT:

VITALS

BP	*(normal)*	
Pulse	*Resp.*	
Ht.		*°F*
Wt.	/	*°C*

Notes:

HIPPA Notice of Privacy Practices

How We Collect Information About You: Thermography Wellness Center and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, the patient intake form, and any medical information that you provide.

What We Do / Do Not Do With Your Information: Information about your medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to intake form, directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about patients that receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Use Your Information: Information is only used as is reasonably necessary to provide you with health services which may require communication between TWC and health care providers, medical providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need, and ONLY at your specific request.

Information We Do Not Collect: We do not use cookies on our website to collect date from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page (www.ThermograpyWellnessCenter.com) that simply records the number of visitors and no other data.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of TWC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for research, education, training, informational and marketing purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used.

You may specifically request that NO information be used whatsoever for research/information/marketing purposes, but you must identify any requested restrictions in writing below. We respect your right to privacy and assure you no identifying information or images will ever be publicly used.

☐ TWC may use my non-identifying images for research, education, training or informational purposes.

☐ TWC may not use my non-identifying images for research, education or informational purposes.

☐ TWC may use my written, photo, video and/or audio testimonials for marketing purposes.

Printed Name _____ Patient Signature _____ Date _____

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After Your Exam Would You Do Us the Favor Of A Video or Written Comment To Share With Others?

Thermography Wellness Center

Name Last Initial / City _____