Healthworks
NUTRITION CENTRE

Breast Health History – page 1

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Cell: _____ Home: _____ E-mail: _____

Occupation: _____ Marital Status: S M D W SEP # of Children: _____

❒ Y ❒ N Do you have a family history of breast cancer?
❒ Self ❒ Mother ❒ Maternal Grandmother ❒ Sister ❒ Daughter ❒ None

❒ Y ❒ N Do you have any diagnosed breast conditions?
❒ None ❒ Fibrocystic ❒ Cystic ❒ Other _____

❒ Y ❒ N Have you previously had a thermogram? Date of most recent _____
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Being watched ❒ R ❒ L Breast

❒ Y ❒ N Have you had a mammogram? Date of most recent _____
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Being watched ❒ R ❒ L Breast

❒ Y ❒ N Have you had a breast ultrasound? Date of most recent _____
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Being watched ❒ R ❒ L Breast

❒ Y ❒ N Have you had a breast exam by a doctor? Date of most recent _____
Was it: ❒ Normal ❒ Lump Found ❒ R ❒ L Breast

❒ Y ❒ N Any breast biopsies? When and what type (i.e. needle, core)? _____ ❒ R ❒ L Breast

❒ Y ❒ N Any breast surgeries? When and what was done? _____ ❒ R ❒ L Breast

❒ Y ❒ N Have you had a mastectomy? When? _____ ❒ R ❒ L Breast

❒ Y ❒ N Have you had radiation? When was it last performed? _____ ❒ R ❒ L Breast

❒ Y ❒ N Have your had your ovaries removed? At what age? _____

❒ Y ❒ N Do you have children. At what age was your first full term pregnancy? _____

❒ Y ❒ N Did you nurse for at least three months? How long _____

❒ Y ❒ N Are you currently nursing?

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Breast Health History – page 2

❒ Y ❒ N Are you currently pregnant?

❒ Y ❒ N Are you currently taking birth control pills?
At what age did you start? _____ for how many years? _____

❒ Y ❒ N Are you in menopause? At what age did it begin? _____

❒ Y ❒ N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?
How many years taken? _____

❒ Y ❒ N Are you currently using natural progesterone cream?
Applied to ❒ Breasts only ❒ Rotating body areas

❒ Y ❒ N Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen? Explain _____

❒ Y ❒ N Do you feel that you are overweight? How many pounds overweight? _____

Are you experiencing any of the following with your breasts?

❒ Y ❒ N A lump. Date found: _____ by ❒ Self ❒ Doctor ❒ R ❒ L Breast
It is: ❒ Hard ❒ Soft ❒ Mobile ❒ Tender

❒ Y ❒ N Pain ❒ R ❒ L Breast
It is ❒ Dull ❒ Sharp ❒ Burning ❒ Stinging ❒ Tender ❒ Changes with my cycle

❒ Y ❒ N Thickening ❒ R ❒ L Breast

❒ Y ❒ N Skin changes (❒ Color ❒ Texture ❒ Over the lump)

❒ Y ❒ N Nipple discharge ❒ R ❒ L Breast
It is ❒ Bloody ❒ Milky ❒ Through one duct ❒ through multiple ducts

❒ Y ❒ N Nipple retraction ❒ R ❒ L Breast

❒ Y ❒ N Nipple changes ❒ R ❒ L Breast
Change in: ❒ Color ❒ Texture

❒ Y ❒ N Other _____

Please note any other concerns/issues you may have: _____

_____

_____

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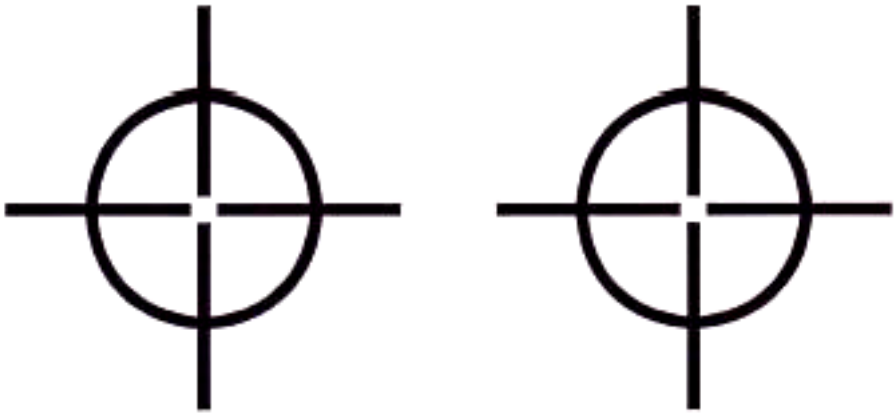
Breast Health History – page 3

Place an [O] on the diagram in the exact area of the lump, findings on your mammogram, or area being watched, and a [X] in the area of pain, tenderness, thickening, or skin changes.



Right Breast Left Breast

General Health Information

❒ Y ❒ N Do you have any medical complaints or conditions? Please explain _____

_____

❒ Y ❒ N Are you currently taking any medications? Please list _____

_____

Please circle all of the following conditions which you have had:

Abscesses	Depression	Heart Disease	Mononucleosis	Rheumatic Fever	Syphilis
Addiction	Diabetes	Hepatitis	Mumps	Rubella	Tonsillitis
Allergies	Emphysema	Herpes Genitalia	Parasites	Scarlet Fever	Tuberculosis
Amnesia	Epilepsy	Influenza	Pelvic Inflammatory	Sexual Abuse	Typhoid Fever
Arthritis	Gall Stones	Kidney Disease	Disease	Skin Disease	Venereal Warts
Asthma	Goiter	Leukemia	Peritonitis	Strep Throat	Warts
Cancer	Gonorrhea	Malaria	Pleurisy	Sinusitis	Whooping Cough
Chicken Pox	Gout	Measles	Pneumonia	Sunstroke	Worms
Cold Sores	Hay Fever	Miscarriage	Prostatitis	Stroke	Yellow Fever

Other _____

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Breast Health History – page 4

❒ Y ❒ N Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Explain? _____

_____

❒ Y ❒ N Have you had any operations? Which _____

❒ Y ❒ N Have you lost any weight recently? How many pounds? _____

❒ Y ❒ N Do you exercise? How often? _____

❒ Y ❒ N Have you had any major injuries? Explain _____

❒ Y ❒ N Are you taking any of the following substances? How much?

Tobacco: _____ Alcohol: _____

Coffee: _____ "Recreational Drugs" _____

❒ Y ❒ N Have any of the following ailments affected your relatives?

Alcoholism	Asthma	Diabetes	Gout	Mental Illness	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

FAMILY HISTORY	Age, if Alive	Age at Death	AILMENTS
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			

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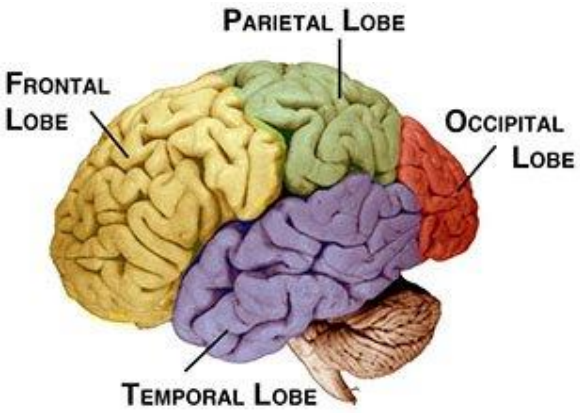
Cranial/Dental Health History – page 1



Yes/No Headaches?
Please circle: Dull/Sharp/Cluster/Sinus/Other

Describe other: _____

_____

Which side? Right side/Left side

Which lobe? *(see diagram to the left, circle below)*

Frontal *(top front)*/ Parietal *(top back)*/
Temporal *(side)* / Occipital *(back)*

Yes/No Nasal Condition? Right side/Left side

Yes/No Allergies?
Type? Seasonal Hay Fever / Food / Dust / Mold / Pets / Unknown

Yes/No Have you ever been diagnosed with Cerebral Circulatory Problems?
Please explain: _____

Yes/No Have you been diagnosed with a thyroid condition?
Which? Hypo / Hyper
Type? Hashimoto's / Grave's / Goiter / Cancer / Unknown

Yes/No Other Conditions?
Describe: _____

_____

Yes/No Do you have a specific dental problem?
Describe: _____

Yes/No Do you have dental examinations on a routine basis?
Date of last visit: _____

Please indicate if you have any of the following conditions:

Yes/No Have you ever been diagnosed with Temporomandibular Joint Disorder (TMJ)?

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Cranial/Dental Health History – page 2

Yes/No Root Canal Treatments ❒ Upper Left ❒ Upper Right
❒ Lower Left ❒ Lower Right

Yes/No Do your gums ever bleed?

Yes/No Do you clench or grind your teeth?

Yes/No Does your jaw hurt or click? ❒ R ❒ L

Yes/No Do you have any difficulty chewing?

Yes/No Do you think you have active decay or gum disease?

Please note any other concerns/issues you may have:

_____

_____

_____

GENERAL HEALTH INFORMATION

Do you have any medical complaints or conditions? Yes/No

Please explain: _____

_____

Are you currently taking any medications? Yes/No

Please list: _____

_____

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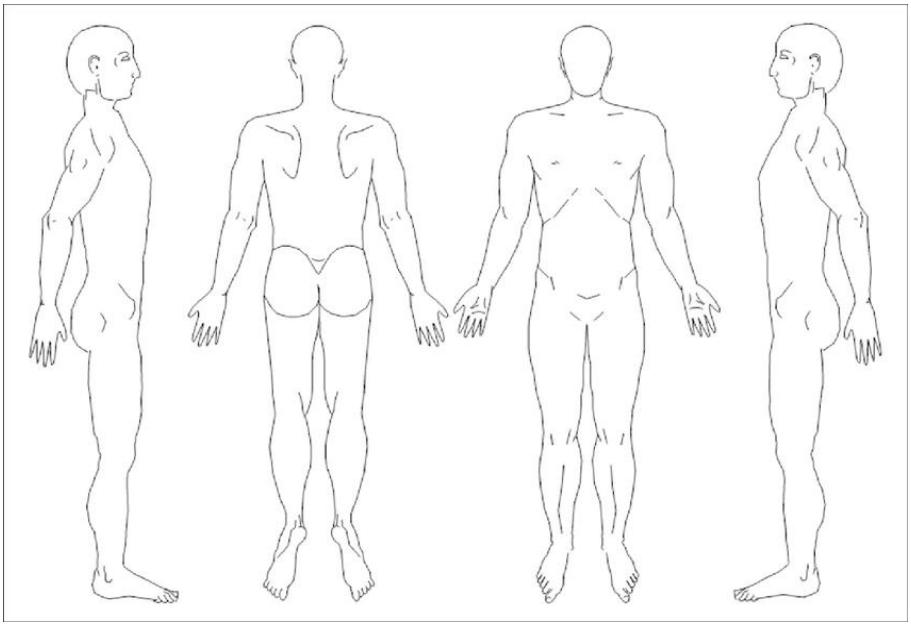
Pain History

Mark the location of your symptoms with and "X" and label it as sharp, dull, burning, aching, etc.



Please note level of Pain 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10

Mild/Annoyance Moderate/Some limitations Severe/Pain Killers needed

Describe your symptoms: _____

_____

How and when did this start: _____

_____

Were you examined for this complaint: ❒ Y ❒ N Dates: _____

Results: _____

What increases your symptoms: _____

What decreases your symptoms: _____

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Release for Test Procedure

Thermal imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging exams.

I have complied with the pre-examination instructions for proper thermal imaging.

Name: _____ Date: _____

Signature: _____

For clinic use only:

❒ Initial Exam ❒ Re-Exam Patient Temp. ____ F Clinic Temp. ____C

Clinician: _____

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