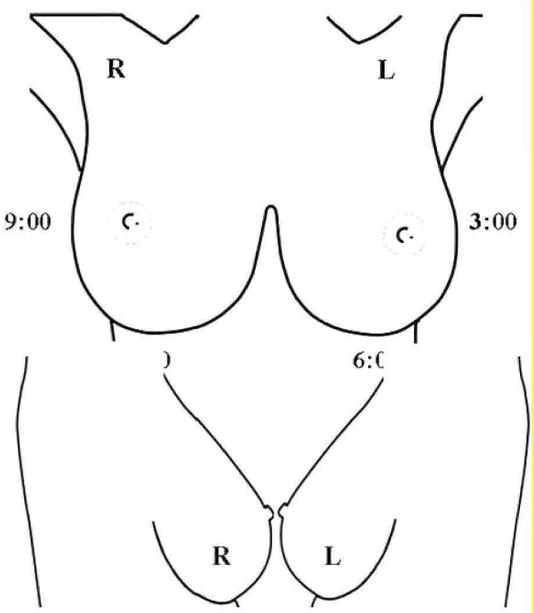
Global Solutions Foundation

Name: _____ Birth Date: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
E-Mail: _____ Home Ph. # _____ Cell Ph.# _____
Emergency Contact: _____ Home Ph.# _____
Receive your report : In person / Mail / E-Mail Last Thermogram: / /

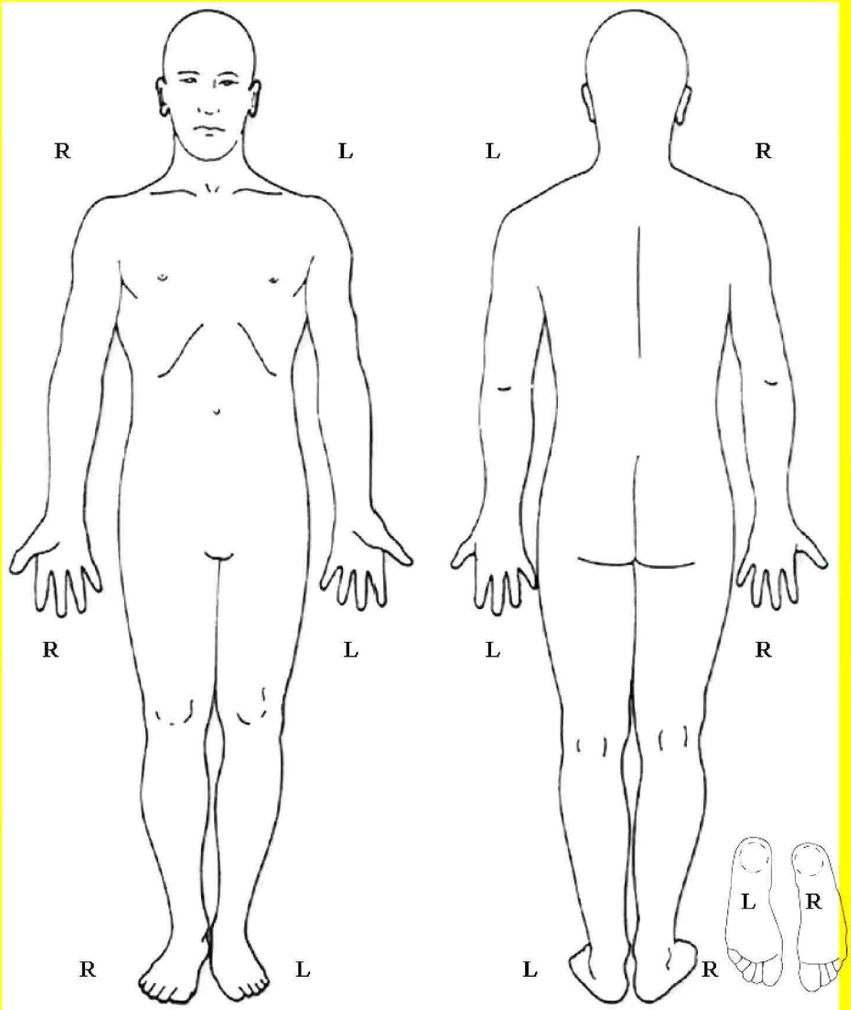
Breast Questionnaire - Occupation: _____ I was referred by _____

have you had the following:
Diagnosed with breast cancer? **Yes / No**
If yes: **type- Metastatic / Lymphatic node removal / Local** *When:* / /
Diagnosed of other breast disease? **Yes / No**
_____
Biopsies and your findings? **Yes / No**
_____
Breast surgery/ implants? **Yes / No**
Mammogram last 12 months? **Yes / No**
Total mammograms #_____
First mammogram #_____
Contraceptive over 1 year? **Yes / No**
Hormone therapy? **Yes / No**
Doctors last breast exam? / /
Monthly breast self exams? **Yes / No**
Menstrual periods before 12? **Yes / No**
Menstrual stopped after 50 ? **Yes /No**
Total births #?____, age of first born? ____

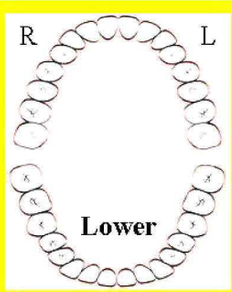
Breast symptoms in the last 6 months?
Please demonstrate symptoms with following symbols: "**T**" for **T**enderness; "**L**" for Lumps; "**D/T**" for Nipple **D**impling /**T**hickening. **C**hange in **s**ize "**CS**"; "**NS**" **N**ipple **s**ecretion, **B**iopsy "**B**" .



Please demonstrate symptoms with the following symbols with accurate locations on the body figure below: "**N**" for **n**umbness; "**1-10**" for pain **10** being the **w**orst; "**S**" for **s**cars; "**M**" for **m**oles; "**F**" for **f**ractures; "**X**" for previous surgeries or current/prior diseases with a line to a brief description.



Current Issues /Accidents? _____
_____
Current medications _____
_____
_____
_____
_____
_____



Teeth/ Gum symbols of history: please use the following letters when marking the areas of the mouth: **R**oot **C**anal "**RC**"/**C**rown "**C**"/**S**urgery "**S**" **M**ercury **F**illings "**MF**"/ "**O**" = Other

Patient Disclosure

I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, analysis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis , or treatment. I understand the report will not tell me whether I have an illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by ***Thermography Unlimited, LLC/ Total Thermal Imaging*** *.*

For Office Use Only: **First Visit** **3 month** **1 YR Recall** **Super Bill**

Description _____ **Cost $** _____

Payment Method: **Check#** _____ **Check / Cash $** _____

Credit Card # _____ **Exp. Date:** _____
Visa **MasterCard** **Discover**
Billing Address _____
SAME AS ABOVE

Patient Signature : _____ *Date:* _____
Signature Authorizing Payment