Central Florida Thermography, LLC

1555 Howell Branch Rd.
Suite B-2
Winter Park, FL 32789
Phone: 407-622-9090
cflthermography.com

Intake Forms: All information given in the questionnaire will remain strictly confidential and will only be released to the reading Thermologist and any other practitioner that you specify.

Today's Date:	
Name:	**DOB:**
Address:	
Phone:	**Cell Phone:**
Email:	

Physician Information:

Name:
Mailing Address:
Phone:
I would like a copy of my thermography report sent to the above listed provider: Yes ☐ No ☐

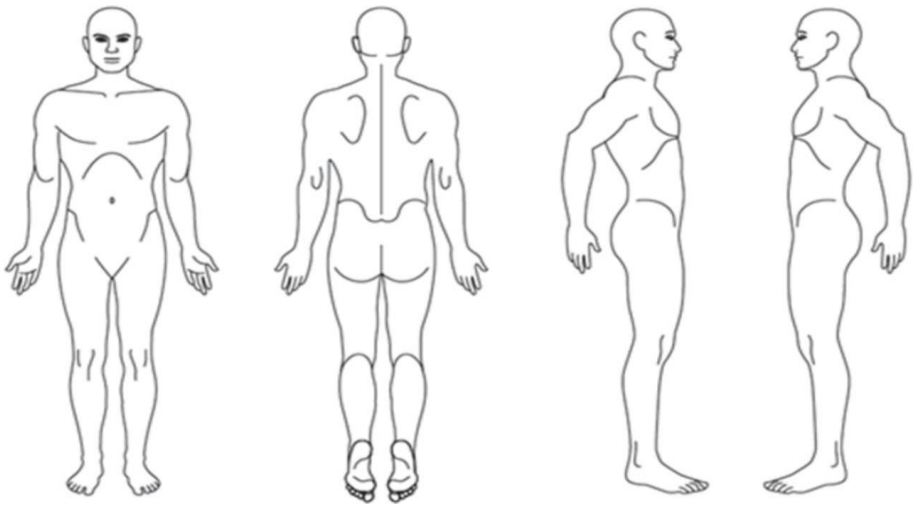
Additional Provider Information:

Name:
Mailing Address:
Phone:
I would like a copy of my thermography report sent to the above listed provider: Yes ☐ No ☐

Medical History:

Previous Illness	
Previous Surgery	
Current or Previous Injuries or Fractures	
Current Health Concerns	
Current Medications	
Other Treatments	
Have you had a vaccine in the past 4 weeks? ***Yes*** ☐ ***No*** ☐ **If yes, indicate which arm:** ***Left*** ☐ ***Right*** ☐	

Areas of Concern:



Please identify areas of:

*Main Pain: **

*Secondary Pain: **

Numbness: 0

Pins and Needs: |||

Skin lesions/scaring: ::::

Do you know what triggers the pain?	
Does anything relieve it?	
Does anything aggravate it?	
Has it changed since it began?	
Have you had any treatment?	

Breast Thermography Confidential Questionnaire:

Do you have any close relatives who have had breast cancer?	***Yes*** ☐ ***No*** ☐
Have you ever been diagnosed with breast cancer?	***Yes*** ☐ ***No*** ☐
Have you ever been diagnosed with any other breast disease?	***Yes*** ☐ ***No*** ☐
Have you had any biopsies or surgeries to your breasts?	***Yes*** ☐ ***No*** ☐
Have you had any breast cosmetic surgery or implants?	***Yes*** ☐ ***No*** ☐
Have you had a mammogram in the past 12 months?	***Yes*** ☐ ***No*** ☐
Have you had a mammogram in the past 5 years?	***Yes*** ☐ ***No*** ☐
Have you had abnormal results from any breast testing?	***Yes*** ☐ ***No*** ☐
Have you ever taken a contraceptive pill for more than 1 year?	***Yes*** ☐ ***No*** ☐
Have you suffered with cancer of the womb?	***Yes*** ☐ ***No*** ☐
Have you had pharmaceutical hormone replacement therapy?	***Yes*** ☐ ***No*** ☐
Do you have an annual physical examination by a doctor?	***Yes*** ☐ ***No*** ☐
Do you perform a monthly breast exam?	***Yes*** ☐ ***No*** ☐
How many mammograms have you had in total?	
What was the age when you had your first mammogram?	
How many births have you had?	
Your age at birth of your first child:	
Did your periods start before age 12?	***Yes*** ☐ ***No*** ☐
Did your periods finish after age 50?	***Yes*** ☐ ***No*** ☐
Do you smoke? *Yes* ☐ *Never* ☐ *Not in the last 12 months* ☐ *Not in the last 5 years* ☐	
Have you recently had any of these breast symptoms?	
Pain	***Right Breast*** ☐ ***Left Breast*** ☐
Tenderness	***Right Breast*** ☐ ***Left Breast*** ☐
Lumps	***Right Breast*** ☐ ***Left Breast*** ☐
Change in breast size	***Right Breast*** ☐ ***Left Breast*** ☐
Areas of skin thickening or dimpling	***Right Breast*** ☐ ***Left Breast*** ☐
Secretions from the nipple	***Right Breast*** ☐ ***Left Breast*** ☐

Extended Breast Questionnaire

None of the below is applicable ☐

Cancer Type	Metastatic ☐ Local ☐ Lymph Node Involvement ☐				
Date Diagnosed					
Location (Left Breast)	**Upper Outer (UO)** ☐	**Upper Inner (UI)** ☐	**Lower Outer (LO)** ☐	**Lower Inner (LI)** ☐	**Nipple** ☐
Location (Right Breast)	**UO** ☐	**UI** ☐	**LO** ☐	**LI** ☐	**Nipple** ☐
Treatment	**Surgery** ☐ **Chemotherapy** ☐ **Radiation** ☐ **Other: _____** **None**☐				

Diagnosed with Other Breast Disease:

Disease Type	**Fibrocystic** ☐ **Cystic** ☐ **Mastitis** ☐ **Abscess**☐ **Other:**

Breast Biopsies or Surgery:

Location (Left Breast)	**UO** ☐	**UI** ☐	**LO** ☐	**LI** ☐	**Nipple** ☐
Location (Right Breast)	**UO** ☐	**UI** ☐	**LO** ☐	**LI** ☐	**Nipple** ☐

Patient Disclosure

I understand that the report generated from my images is intended for use by trained healthcare providers to assist in evaluation, diagnosis, and treatment. I further understand that the report is not intended to be used by individuals for self-evaluation and/or self-diagnosis. I understand that the report will not tell me if I have any disease, illness, or other condition. The report will be an analysis of the images with respect to the thermographic findings discussed within it.

By signing below, I certify that I have read and understand the statements above and consent to the examination.

Signature: _____ Today's Date: _____

Central Florida Thermography, LLC

Authorization to Use or Disclose Protected Health Information

Central Florida Thermography, LLC

Patient Name**:** _____

Address: _____

Date of Birth: _____ Date of Request**:**_____

As required by the Privacy Regulations, *Central Florida Thermography, LLC* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of:

1) EMI, Electronic Medical Interpretations

2) _____

3) _____

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail):

1) Interpretation of said images

2) _____

3) _____

Effective dates for this authorization: Seven years from the date of signature below.
This authorization will expire at the end of the above period.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Patient or Patient's Authorized Representative *Date*

_____ _____
Authorized *Signature of Facility* *Date*

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