Chest and Breast Study

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip___

Phone Number (cellular)_____(work)_____

Email_____ Referring Physician_____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Breast

1. Have you recently had any of these breast symptoms? (Mark only if "yes")

	RT	**LT**
Pain/Tenderness	____	____
Lumps or palpable masses	____	____
Change in breast size	____	____
Areas of skin changes thickening or dimpling	____	____
Excretions or changes of the nipple	____	____

2. Are any of the above symptoms cycle related? (Mark only if "yes") _____

3. Are you still having periods? If yes: Date of last period _____

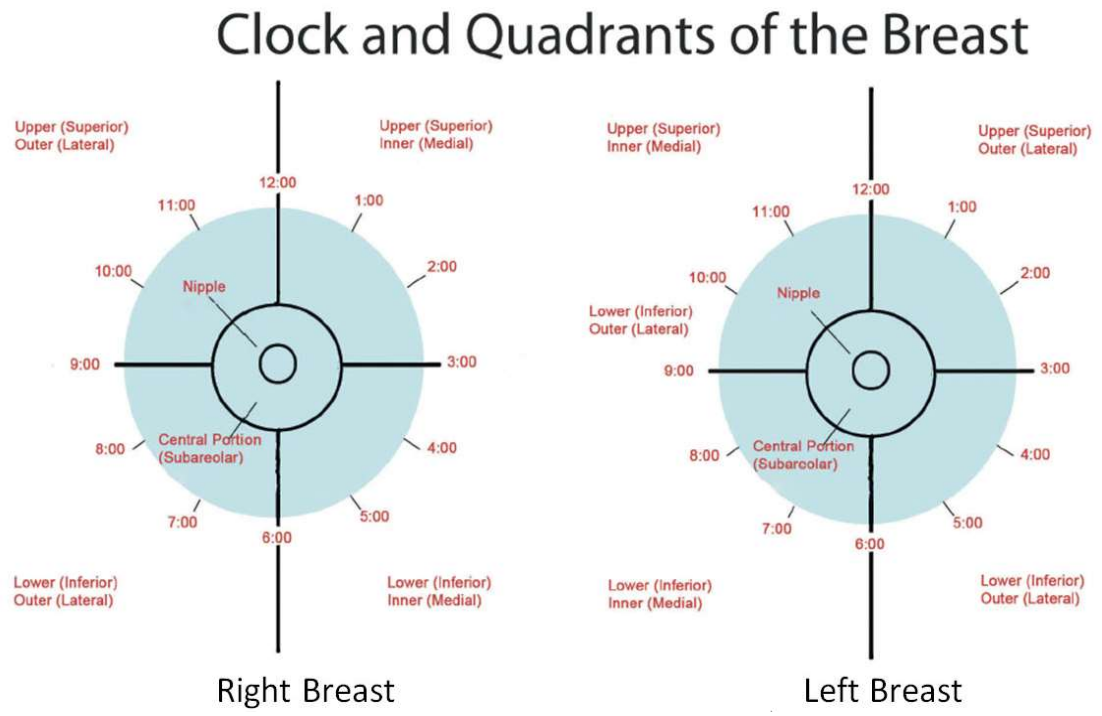
4. Have you had a surgical hysterectomy?

If yes: Date_____ Complete___ Partial___

Reason for hysterectomy?

__ Excess bleeding __Endometriosis __Fibroid cysts __Cancer __Other

Mark on the following graph to indicate location of pain, surgery or lumps:



5. Has anyone in your family been treated for breast cancer?
___Mother ___Grandmother ___Sister ___Daughter

Age diagnosed_____ Result of treatment_____

6. Have you ever been diagnosed with breast cancer?

If yes, date of diagnosis: Month _____Year_____ Date of treatment: Month_____Year_____

Cancer type ___Local ___Metastatic ___Lymph node involvement

Left breast ___Inner ___Outer ___Nipple

Right breast ___Inner ___Outer ___Nipple

Treatment ___Surgery ___Chemo ___Radiation ___None

If surgery ___Mastectomy ___Lumpectomy

7. Have you been diagnosed with any other breast disease?

If yes: Cysts/fibrocystic___ Fibro Adenoma___ Mastitis/inflammatory breast disease___

8. Have you had any cosmetic breast surgery or implants?
If yes, date_____ Silicone___ Saline___ Reduction___

Experience: ___Problems ___No problems

9. Have you had any biopsies or any other surgeries to your breasts?
If yes, date_____

Left breast ___Inner ___Outer ___Nipple

Right breasts ___Inner ___Outer ___Nipple

Results ___Negative ___Positive ___Calcifications

10. Have you ever taken contraceptive pills for more than one year?
If yes: ___Currently ___Less than 5 years ___More than 5 years

11. Have you ever had hormone replacement therapy?
If yes: ___Currently ___Less than 5 years ___More than 5 years

12. Do you have an annual physical examination by a doctor? If yes, date of last visit_____

13. Do you perform a monthly self-exam? If yes, how often? _____

14. Have you ever smoked? If yes, for how long? _____ Packs/Day____

15. Have you ever been diagnosed with diabetes? If yes, date_____

16. Total number of Mammograms_____

17. Date of last Mammogram_____ Were you re-called? _____

18. Your age at your first Mammogram_____

19. Number of full term pregnancies? _____

20. Have you ever had a breast ultrasound?
If yes, date_____ Left___ Right____ Results: Negative___ Positive___

21. Have you had a breast MRI?
If yes, date_____ Left___ Right____ Results: Negative___ Positive___

Chest, Heart, and Upper Back

1. Have you ever been diagnosed with:

   Heart disease? If yes, date_____

   Lung disease? If yes, date _____

   Upper spine disorders? If yes, date _____

2. Do you suffer with upper back pain? If yes, date when pain started _____

3. Do you suffer with chest pain? If yes, date when pain started _____

4. Have you been diagnosed with scoliosis? If yes, date when pain started _____

5. Have you ever had surgery related to your:

   Heart? _____

   Lungs? _____

   Mid to upper back? _____

6. Do you have asthma or shortness of breath? ____

7. Do you currently smoke? ____

8. Have you ever smoked? If yes, for how long_____ Packs/Day____

9. Do you suffer with shoulder pain?

If yes, date when pain started _____ Left _____ Right _____