# *Women's Full Body Study*

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (cellular)_____(work)_____

E-Mail Address_____Referring Physician _____

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

## *Head & Neck*

1. Do you suffer with headaches?

If yes, once a month or less____ More than once a month____ No____

2. Do you have any known allergies?

If yes, food____ Environmental_____ No____

3. Do you have TMJ or does your jaw click?

Yes____ No____

4. Do you currently have a cold?

Yes____ No____

5. Are you being treated for a thyroid disorder?

If yes, what type? _____ No____

6. Do you have neck pain?

Yes____ No____

7. Do you have upper back pain?

Yes____ No____

8. Do you have a known history of carotid artery disease?

Yes____ No____

9. Do you have a family history of stroke?
Yes____ No____

10. Do you currently suffer with sinus problems?
Yes____ No____

11. Do you have a history of dental problems?

If yes, Root canals ____ Gum disease ____ Implants ____ Non-replaced extractions ____

Dentures ____ No____

12. Have you had dental cleaning in the past 7 days?
Yes____ No____

13. Have you been diagnosed with elevated cholesterol?
Yes____ No____

## *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 | ____ | ____ |

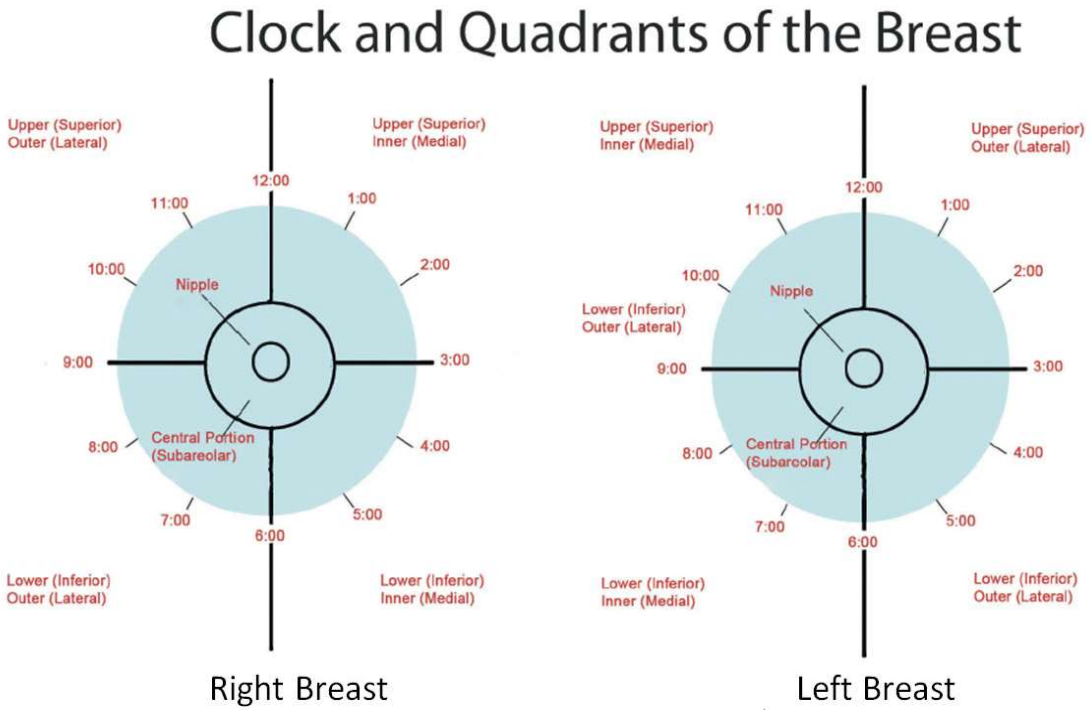
2. Are any of the above symptoms cycle related? (Mark only if "yes") _____

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

If yes, 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 & Lungs*

1. Have you ever been diagnosed with:
Heart disease ____ Lung disease ____ Upper spine disorders____

2. Do you suffer with upper back pain?
Yes____ No____

3. Do you suffer with chest pain?
Yes____ No____

4. Have you ever been diagnosed with scoliosis?
Yes____ No____

5. Have you ever had surgery to your:
Heart____ Lungs____ Mid to upper back____

6. Do you have asthma or shortness of breath?
Yes____ No____

7. Do you currently smoke?
Yes____ No____

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

9. Do you suffer with shoulder pain?
If yes, Left____ Right____ No____

## *Abdomen & Lower Back*

1. Do you suffer with acid reflux or other digestive problems?
Yes____ No____

2. Do you suffer with pain in the:
Stomach____ Abdomen____

Below left breast____ Lower Back____

Below right breast____ Pelvic Region____ No____

3. Have you ever had surgery or disease in the:
Stomach____ Intestines____

Spleen (Upper Left) ____ Abdomen____

Liver (Upper Right) ____ Lower back____

Kidneys____ Pelvic region____ No____

4. Have you consumed alcohol in the past 24 hours?
Yes____ No____

## *Legs & Feet*

1. Do you suffer with pain in the: (Check only if "yes")
Leg Lt___ RT___ Knees LT___ RT___

Sciatica LT___ RT___ Feet LT___ RT___

Buttocks/Hip LT___ RT___ Ankles LT___ RT___

2. Have you ever had surgery to: (Check only if "yes")
Leg LT___ RT___ Knees LT___ RT___

Sciatica LT___ RT___ Feet LT___ RT___

Buttocks/Hip LT___ RT___ Ankles LT___ RT___

## *Arms & Hands*

1. Do you suffer with pain in the: (Check only if "yes")

Shoulder LT___ RT___ Arm LT___ RT___

Elbow LT___ RT___ Hands LT___ RT___

2. Have you had surgery to: (Check only if "yes")

Shoulder LT___ RT___ Arm LT___ RT___

Elbow LT___ RT___ Hands LT___ RT___

## *Areas of pain*

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