Greenpoint thermography

BREAST THERMOGRAPHY QUESTIONNAIRE

1. Any family history of breast cancer (mother, sister, daughter; or multiple relatives)? Yes __ No __
2. Ever been diagnosed with breast cancer? Yes __ No __
3. Ever been diagnosed with any other breast disease? Yes __ No __
4. Ever had any biopsies or surgeries to your breasts? Yes __ No __
5. Ever had any breast cosmetic surgery or implants? Yes __ No __
6. Have you had a mammogram in the past 12 months? Yes __ No __
7. Have you had a mammogram in the past 5 years? Yes __ No __
8. Have you had abnormal results from any breast testing? Yes __ No __
9. Have you ever taken a contraceptive pill for more than 1 year? Yes __ No __
10. Ever been diagnosed with endometrial cancer (of the uterus)? Yes __ No __
11. Ever had hormone replacement therapy? Yes __ No __
12. Have you had a physical examination by a doctor in the past year? Yes __ No __
13. Do you perform a monthly self-breast examination? Yes __ No __
14. How many mammograms have you had in total? _____
15. Age at first mammogram? _____
16. How many children do you have? Age at birth of first child? _____
17. Did your periods start before the age of twelve? Yes __ No __
18. Or finish after the age of 50? Yes __ No __
19. Do you smoke? Yes __ Never __ Not in last 12 months __ Not in last 5 years __

Have you recently had any of these breast symptoms?	Right	Left
1. Pain	____	____
2. Tenderness	____	____
3. Lumps	____	____
4. Change in breast size	____	____
5. Skin thickening/dimpling	____	____
6. Secretions of the nipple	____	____

<u>Diagnosed with Breast Cancer</u>

Cancer type: _____

Metastatic: ____ Local ____ Lymph Node Involvement ____

When diagnosed: Month: _____ Year: _____

Where:	Right	Left
Upper outer	____	____
Upper inner	____	____
Lower outer	____	____
Lower inner	____	____
Nipple	____	____

Treatment:

	Yes/No	Date completed
Surgery	____	_____
Chemo	____	_____
Radiation	____	_____
Other	____	_____

Please explain: _____
_____
_____

Diagnosed with other Breast Disease

Fibrocystic: ____ Cystic: ____ Mastitis: ____ Abscess: ____ Other: _____

Breast Biopsies or Surgery

Where:	Right	Left	When
Upper outer	____	____	_____
Upper inner	____	____	_____
Lower outer	____	____	_____
Lower inner	____	____	_____
Nipple	____	____	_____

Signature: _____ Date: _____