**Healthworks**
NUTRITION CENTRE

# Breast Health History – page 1

Name: ______________________ Age: ________ Date of Birth: ______________

Address: ______________________ City: ______________ Postal Code: __________

Cell: ____________ Home: ____________ E-mail: ______________________

Occupation: ________________ Marital Status: S M D W SEP # of Children: _______

❒ Y ❒ N Do you have a family history of breast cancer?
❒ Self ❒ Mother ❒ Maternal Grandmother ❒ Sister ❒ Daughter ❒ None

❒ Y ❒ N Do you have any diagnosed breast conditions?
❒ None ❒ Fibrocystic ❒ Cystic ❒ Other ______________________

❒ Y ❒ N Have you previously had a thermogram? Date of most recent ______________
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Being watched ❒ R ❒ L Breast

❒ Y ❒ N Have you had a mammogram? Date of most recent ______________
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Being watched ❒ R ❒ L Breast

❒ Y ❒ N Have you had a breast ultrasound? Date of most recent ______________
Was it: ❒ Normal ❒ Abnormal ❒ Suspicious ❒ Being watched ❒ R ❒ L Breast

❒ Y ❒ N Have you had a breast exam by a doctor? Date of most recent ______________
Was it: ❒ Normal ❒ Lump Found ❒ R ❒ L Breast

❒ Y ❒ N Any breast biopsies? When and what type (i.e. needle, core)? __________ ❒ R ❒ L Breast

❒ Y ❒ N Any breast surgeries? When and what was done? ______________ ❒ R ❒ L Breast

❒ Y ❒ N Have you had a mastectomy? When? ______________ ❒ R ❒ L Breast

❒ Y ❒ N Have you had radiation? When was it last performed? __________ ❒ R ❒ L Breast

❒ Y ❒ N Have your had your ovaries removed? At what age? ______________

❒ Y ❒ N Do you have children. At what age was your first full term pregnancy? __________

❒ Y ❒ N Did you nurse for at least three months? How long ______________

❒ Y ❒ N Are you currently nursing?

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## Breast Health History – page 2

❒ Y ❒ N Are you currently pregnant?

❒ Y ❒ N Are you currently taking birth control pills?
At what age did you start? ________________ for how many years? ____________________________

❒ Y ❒ N Are you in menopause? At what age did it begin? ____________________________________________

❒ Y ❒ N Have you ever taken synthetic hormone replacement (ex. Premarin, Provera)?
How many years taken? __________

❒ Y ❒ N Are you currently using natural progesterone cream?
Applied to ❒ Breasts only ❒ Rotating body areas

❒ Y ❒ N Are you currently using herbals, homeopathic medicines, or supplements to stimulate or simulate estrogen? Explain ______________________________________________________________

❒ Y ❒ N Do you feel that you are overweight? How many pounds overweight? ______________________

**Are you experiencing any of the following with your breasts?**

❒ Y ❒ N A lump. Date found: ______________ by ❒ Self ❒ Doctor ❒ R ❒ L Breast
It is: ❒ Hard ❒ Soft ❒ Mobile ❒ Tender

❒ Y ❒ N Pain ❒ R ❒ L Breast
It is ❒ Dull ❒ Sharp ❒ Burning ❒ Stinging ❒ Tender ❒ Changes with my cycle

❒ Y ❒ N Thickening ❒ R ❒ L Breast

❒ Y ❒ N Skin changes ( ❒ Color ❒ Texture ❒ Over the lump)

❒ Y ❒ N Nipple discharge ❒ R ❒ L Breast
It is ❒ Bloody ❒ Milky ❒ Through one duct ❒ through multiple ducts

❒ Y ❒ N Nipple retraction ❒ R ❒ L Breast

❒ Y ❒ N Nipple changes ❒ R ❒ L Breast
Change in: ❒ Color ❒ Texture

❒ Y ❒ N Other ______________________________________________________________________________

Please note any other concerns/issues you may have: ________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

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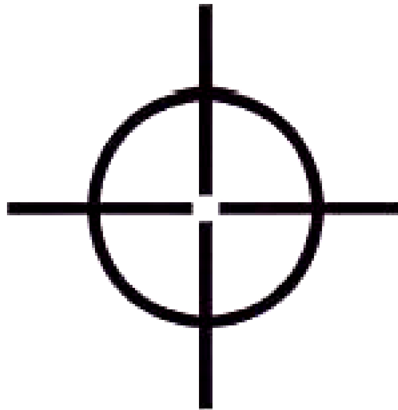
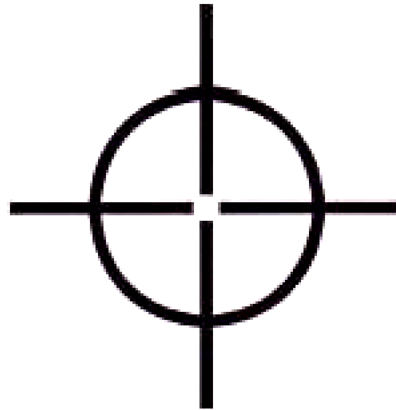
## Breast Health History – page 3

**Place an [O] on the diagram in the exact area of the lump, findings on your mammogram, or area being watched, and a [X] in the area of pain, tenderness, thickening, or skin changes.**



Right Breast



Left Breast

# General Health Information

❐ Y ❐ N Do you have any medical complaints or conditions? Please explain ____________________

______________________________________________________________________________________

❐ Y ❐ N Are you currently taking any medications? Please list ________________________________

______________________________________________________________________________________

**Please circle all of the following conditions which you have had:**

| | | | | | |
|---|---|---|---|---|---|
| Abscesses | Depression | Heart Disease | Mononucleosis | Rheumatic Fever | Syphilis |
| Addiction | Diabetes | Hepatitis | Mumps | Rubella | Tonsillitis |
| Allergies | Emphysema | Herpes Genitalia | Parasites | Scarlet Fever | Tuberculosis |
| Amnesia | Epilepsy | Influenza | Pelvic Inflammatory | Sexual Abuse | Typhoid Fever |
| Arthritis | Gall Stones | Kidney Disease | Disease | Skin Disease | Venereal Warts |
| Asthma | Goiter | Leukemia | Peritonitis | Strep Throat | Warts |
| Cancer | Gonorrhea | Malaria | Pleurisy | Sinusitis | Whooping Cough |
| Chicken Pox | Gout | Measles | Pneumonia | Sunstroke | Worms |
| Cold Sores | Hay Fever | Miscarriage | Prostatitis | Stroke | Yellow Fever |

Other ______________________________________________________________________________

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# Breast Health History – page 4

❒ Y ❒ N Are there any of the preceding conditions after which you have never been totally well again, or which have been more severe than usual? Explain? ____________________
____________________________________________________________________________________

❒ Y ❒ N Have you had any operations? Which ____________________________________________

❒ Y ❒ N Have you lost any weight recently? How many pounds? ______________________________

❒ Y ❒ N Do you exercise? How often? _______________________________________________

❒ Y ❒ N Have you had any major injuries? Explain ___________________________________________

❒ Y ❒ N Are you taking any of the following substances? How much?

Tobacco: _________________________ Alcohol: ___________________________________

Coffee: __________________________ "Recreational Drugs" _______________________

❒ Y ❒ N Have any of the following ailments affected your relatives?

| | | | | | |
|---|---|---|---|---|---|
| Alcoholism | Asthma | Diabetes | Gout | Mental Illness | Skin Disease |
| Allergies | Cancer | Epilepsy | Hay Fever | Paralysis | Syphilis |
| Arthritis | Depression | Gonorrhea | Heart Disease | Pneumonia | Tuberculosis |

| **FAMILY HISTORY** | **Age, if Alive** | **Age at Death** | **AILMENTS** |
|---|---|---|---|
| Mother: | | | |
| Father: | | | |
| Brothers: | | | |
| Sisters: | | | |
| Children: | | | |
| Maternal Grandmother: | | | |
| Maternal Grandfather: | | | |
| Paternal Grandmother: | | | |
| Paternal Grandfather: | | | |

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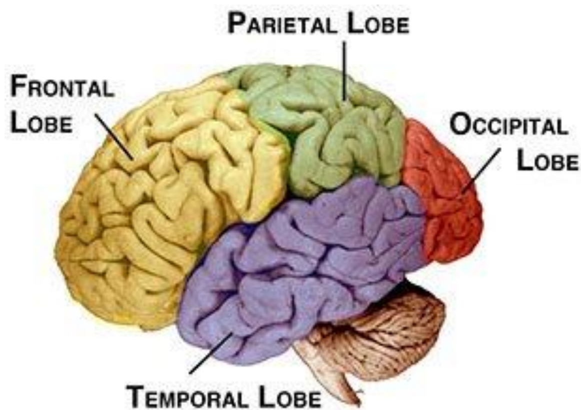
## Cranial/Dental Health History – page 1




Yes/No Headaches?
Please circle: Dull/Sharp/Cluster/Sinus/Other
Describe other: ______________________________________

Which side? Right side/Left side

Which lobe? *(see diagram to the left, circle below)*

Frontal *(top front)*/ Parietal *(top back)*/
Temporal *(side)* / Occipital *(back)*

Yes/No Nasal Condition? Right side/Left side

Yes/No Allergies?
Type? Seasonal Hay Fever / Food / Dust / Mold / Pets / Unknown

Yes/No Have you ever been diagnosed with Cerebral Circulatory Problems?
Please explain: ______________________________________________________________

Yes/No Have you been diagnosed with a thyroid condition?
Which? Hypo / Hyper
Type? Hashimoto's / Grave's / Goiter / Cancer / Unknown

Yes/No Other Conditions?
Describe: ______________________________________________________________

---

Yes/No Do you have a specific dental problem?
Describe: ______________________________________________________________

Yes/No Do you have dental examinations on a routine basis?
Date of last visit: ____________________

Please indicate if you have any of the following conditions:

Yes/No Have you ever been diagnosed with Temporomandibular Joint Disorder (TMJ)?

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## Cranial/Dental Health History – page 2

Yes/No Root Canal Treatments ❒ Upper Left ❒ Upper Right
❒ Lower Left ❒ Lower Right

Yes/No Do your gums ever bleed?

Yes/No Do you clench or grind your teeth?

Yes/No Does your jaw hurt or click? ❒ R ❒ L

Yes/No Do you have any difficulty chewing?

Yes/No Do you think you have active decay or gum disease?

Please note any other concerns/issues you may have:

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

**GENERAL HEALTH INFORMATION**

Do you have any medical complaints or conditions? Yes/No

Please explain: ______________________________________________________________________________

____________________________________________________________________________________________

Are you currently taking any medications? Yes/No

Please list: _________________________________________________________________________________

____________________________________________________________________________________________

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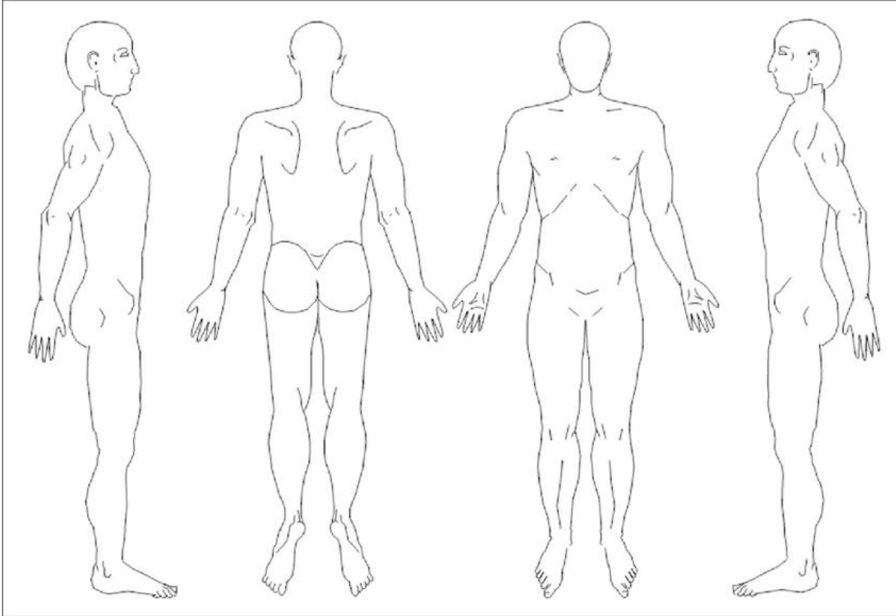
# Pain History

Mark the location of your symptoms with and "X" and label it as sharp, dull, burning, aching, etc.



Please note level of Pain 0.........1..........2.........3..........4..........5..........6..........7.........8.........9.........10

Mild/Annoyance Moderate/Some limitations Severe/Pain Killers needed

Describe your symptoms: ______________________________________________________________________________

______________________________________________________________________________________________

How and when did this start: __________________________________________________________________________

______________________________________________________________________________________________

Were you examined for this complaint: ❒ Y ❒ N Dates: ______________________________________

Results: ______________________________________________________________________________________

What increases your symptoms: ________________________________________________________________

What decreases your symptoms: ________________________________________________________________

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## Release for Test Procedure

Thermal imaging provides physiological and functional diagnostic information and does not replace any other diagnostic procedure.

I have read the above information and understand that I am not receiving a diagnosis based on my thermal scan. I authorize this clinic's personnel to perform this and all subsequent thermal imaging exams.

I have complied with the pre-examination instructions for proper thermal imaging.

Name: ______________________________________________ Date: __________________________

Signature: __________________________________________________

For clinic use only:

❒ Initial Exam ❒ Re-Exam Patient Temp. ____ F Clinic Temp. ____C

Clinician: ____________________________________