BREAST THERMAL INFRARED IMAGING INFORMATION

Patient Information for Breast Screening with Infrared Thermal Imaging

Purpose of Test: The purpose of this test is for early detection of abnormal changes in breasts. Thermal imaging in used in conjunction with physical exams and mammography to aid in detection of breast disease. A thermal image does not replace mammography. Infrared imaging can increase the chance of early detection of breast disease. Like all procedures, it is not a 100% guarantee of detection. *A complete program of breast health includes a monthly self-exam, annual exam by a physician, and annual thermal imaging and mammography (with an initial baseline at 40 years of age).* Ask your health care provider for additional information.

Patient Preparation: Please complete all paperwork prior to your arrival, and bring the paperwork with you to your appointment. If this is not possible, arrive 15 minutes early for your appointment and complete the necessary paperwork at that time. All information is confidential and is used by the physician to evaluate your thermal images.

YOU MUST NOT:

- Use MD Matrix Cream, or any breast cream, at least 24 hours prior to the exam
- Exercise, drink hot beverages, or take a hot shower at least 4 hours prior to the exam
- Smoke 2 hours prior to the exam
- Use lotions or powder on your breast or apply deodorant on the day of the exam
- Shave your underarms the day of the exam

YOU MUST:

- Avoid sun exposure for extended periods of time the day before and day of the exam
- Provide to us a list of medications you are taking, either prior to or at the time of exam
- Notify the technician if you are taking Beta Blockers (high blood pressure medicine)
- Bring a clip to pull your hair off your neck

What to Expect: You will disrobe from the waist up and acclimate to room temperature of approximately 70° for 15 minutes prior to your scan. The scan will take approximately 30 minutes. Notify the scheduling technician if you are disabled or unable to sit or stand for long periods of time. Your complete cooperation is required so all areas can be scanned.

Test Results: The scan will be analyzed after completion. This analysis may take up to two weeks. Please schedule a follow up appointment with a FEM Centre provider to review the results with you. This follow up appointment will be billed to your insurance and you will be responsible for your co-pay amount. Self-pay patients will be responsible for an office visit charge at a discounted rate. Your scan results will include a re-call period from 6 weeks to 12 months.

Patient Signature: _____ Date: _____

Technician Signature: _____ Date: _____

BREAST HEALTH QUESTIONNAIRE

First Name: _____ Last Name: _____ DOB: ____ / ____ / _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile/Work: _____ Email: _____
Have you ever taken birth control pills: ☐ Yes ☐ No Birth control pills taken before 1st pregnancy? ☐ Yes ☐ No
Estrogen: ☐ Yes ☐ No Name of Estrogen taken: _____ Years taken: _____
Progesterone: ☐ Yes ☐ No Age started: _____ Years taken: _____ Currently taking: ☐ Yes ☐ No
Name and type of Progesterone: Prescriptive _____ Natural _____
Oral _____ Cream _____
Other drugs: list (e.g. blood pressure medication, etc.) _____
Supplements/Vitamins: _____
Do you regularly consume soy or flax seeds? ☐ Yes ☐ No If so, how often? _____

Relevant History – General Information to Calculate Risk Index

Current menstrual day number: _____ Total days in cycle: _____ Age began menses: _____ Age menopause began: ____
Hysterectomy: ☐ Yes ☐ No Age _____ Ovaries removed: ☐ Yes ☐ No Age _____ Ovary removed: ☐ R ☐ L
# of pregnancies: _____ Age of 1st pregnancy: _____ # of live births: _____ # of children nursed over 1 month: _____
Are you: ☐ Caucasian ☐ African American ☐ Asian American ☐ Native American ☐ Jewish ☐ Other _____
Lbs overweight: 1-20 lbs _____ 21-40 lbs _____ 41-60 lbs _____61+ lbs _____
Have you experienced ANY blunt force trauma to the chest: ☐ Yes ☐ No
Do you consistently use antiperspirants? ☐ Yes ☐ No

Family History of Breast Cancer

Self: ☐ Yes ☐ No Age: _____ ☐ Mother ☐ Sister ☐ Daughter ☐ Maternal Grandmother

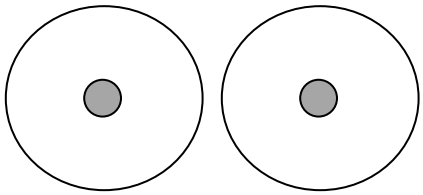
☐ Maternal Aunt ☐ Maternal Cousin ☐ Paternal Grandmother ☐ Paternal Aunt ☐ Paternal Cousin

Have you ever had a breast biopsy: ☐ Yes ☐ No How many? _____ Needle Biopsy: ☐ Yes ☐ No How Many: _____
Surgical Biopsy: ☐ Yes ☐ No ☐ L ☐ R Position _____ Year _____ How Many? _____
Were you told it was: ☐ Benign ☐ Suspicious ☐ Malignant
Lumpectomy? ☐ Yes ☐ No ☐ L ☐ R Year of Surgery: _____ Mastectomy? ☐ Yes ☐ No ☐ L ☐ R Year of Surgery: _____
Radiation of breasts? ☐ Yes ☐ No Month: _____ Year: _____
Chemotherapy: ☐ Yes ☐ No Month: _____ Year: _____

Physical Exam – If you are affected by any of these conditions, write the letter on the breast diagram below.

A.) Mass B.) Thickening C.) Discharge D.) Nipple Discharge E.) Skin Change F.) Area of Pain
G.) Burning H.) Tenderness I.) Dull Ache J.) Sharp Pain K.) Implants

Date of Last: Thermal Image: _____ ☐ Normal ☐ Abnormal
Mammogram: _____ ☐ Normal ☐ Abnormal
Breast Ultrasound: _____ ☐ Normal ☐ Abnormal



Right Breast Left Breast

The information supplied is, to my knowledge, true and complete:

Patient Name (printed): _____ Technician Initials: _____

Patient Signature: _____ Date: _____

RELEASE FOR TESTING PROCEDURE

Infrared thermal scan is a non-contact, non-invasive test which demonstrates physiological patterns of your body. It is not a stand-alone diagnostic test. No surgical procedure should be based on breast thermal imaging alone. Procedures such as mammography, ultrasound, palpitation, biopsy, etc., may be needed to arrive at a final diagnosis. The information provided by your thermal scan is combined with your history to enable your health care provider to plan an approach to your care. The report is called a thermogram.

A licensed medical practitioner is the only qualified person to formulate a diagnosis. He or she must combine Thermographic studies with your additional clinical and testing information to determine your problem. The scan provides evidence of thermal asymmetries that may be present. An asymmetry may be indicative of vascular, neurological, muscular, or other physiological problems.

PLEASE READ CAREFULLY.

Please ask questions if there is anything that you do not understand on this consent form.

I have read the above information and I understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that a thermal scan is non-invasive, and is reading the thermal patterns on the surface of my body. From this information a qualified practitioner will interpret any thermal abnormality displayed. A thermal image is not a replacement for a mammogram.

I understand that my thermogram results may be used for research purposes. No information which would reveal my identity, including my name and any other personal information, will be used for this research. My results, age, and gender are the only factors that would be used in this research.

I am aware that this procedure is not covered by my insurance and that the office fee is due and payable at the time of service.

Printed Name: _____

Signature: _____ Date: _____

Signature of Scanning Technician: _____

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	------	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

‡In the same individual or on the same side of the family

§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Hereditary Colon Cancer - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ 10 or more cumulative colorectal adenomas at any age

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome, MAP, AFAP, or FAP syndrome mutation in the family
- ☐ One or more relatives with 10 or more cumulative colorectal polyps (adenomas) at any age

¶ MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*

^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____