



Confidential Questionnaire

Men's Comprehensive Full Body

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ (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.

Yes No

Head & Neck

1. Do you suffer with headaches? _____

If yes, once a month or less _____ more than once a month _____

2. Do you have known allergies? Food _____ Environmental _____

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

4. Do you currently have a cold? _____

5. Are you being treated for a thyroid disorder? Type _____

6. Do you have neck pain? _____

7. Do you have upper back pain? _____

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

9. Do you have a family history of stroke? _____

10. Do you currently suffer with sinus problems? _____

11. Do you have history of dental problems? _____

Root canals _____ Gum disease _____ Implants _____

Non-replaced extractions _____ Dentures _____

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

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

- | | Yes | No |
|--|------------|-----------|
| 1. Have you been diagnosed with: | | |
| Heart disease? | ___ | ___ |
| Lung disease? | ___ | ___ |
| Upper spine disorders? | ___ | ___ |
| 2. Do you suffer with upper back pain? | ___ | ___ |
| 3. Do you suffer with chest pain? | ___ | ___ |
| 4. Have you ever had surgery to your: | | |
| Heart? | ___ | ___ |
| Lungs? | ___ | ___ |
| Mid to upper back? | ___ | ___ |
| 5. Do you have asthma or shortness of breath? | ___ | ___ |
| 6. Do you currently smoke? | ___ | ___ |
| 7. Have you smoked in the past 5 years? | ___ | ___ |
| 8. Have you consumed alcohol in the past 24 hours? | ___ | ___ |

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

1. Do you suffer with acid reflux or other digestive problems? Yes___ No___	Have you had surgery or disease in the:
2. Do you suffer pain in the:	Stomach? Yes___ No___
Stomach? Yes___ No___	Spleen(Upper Left) ? Yes___ No___
Below R Breast? Yes___ No___	Liver(Upper Right) ? Yes___ No___
Below L Breast? Yes___ No___	Kidneys ? Yes___ No___
Abdomen? Yes___ No___	Intestines ? Yes___ No___
Lower Back? Yes___ No___	Abdomen ? Yes___ No___
Pelvic Region? Yes___ No___	Lower Back? Yes___ No___
	Pelvic Region? Yes___ No___

Legs & Feet

Check only if "Yes"

1. Do you suffer pain in the:	2. Have you had Surgery to:
Leg? LT___ RT___	Leg? LT___ RT___
Sciatica LT___ RT___	Sciatica? LT___ RT___
Buttocks/Hip? LT___ RT___	Buttocks/Hip? LT___ RT___
Knees? LT___ RT___	Knees? LT___ RT___
Ankles? LT___ RT___	Ankles? LT___ RT___
Feet? LT___ RT___	Feet? LT___ RT___

Do you have any special concerns or are there any details related to the information above?

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	LT	RT	2. Have you had surgery to:	LT	RT
Shoulder?	___	___	Shoulder?	___	___
Elbow?	___	___	Elbow?	___	___
Arm?	___	___	Arm?	___	___
Hands?	___	___	Hands?	___	___

Do you have any special concerns or are there any details related to the information above?

Procedure: You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.

Client Disclosure: I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.

By signing below, I certify that I have read and understand the statement above and consent to the examination.

Client Signature _____ Today's Date _____