THERMO-TECH INC.

BREAST THERMOGRAPHY INTAKE FORM

Client Number _____ Retake Date _____ Date _____

Female _____ Male _____ Ethnicity _____ Location of Screening _____

First Name_____Last Name_____Maiden Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____Birth Date _____Birth Place _____ Age__

M – D- Yr

Referring Physician _____Patient's E-mail _____

Permission to email report my Thermography report, signature _____

PATIENTS MEDICAL HISTORY

Reproductive History:

Pregnant now _____ **Days since last menses** _____ Menstrual Start Age _____

Menstrual Stop Age_____ **Caused From**: Menopause _____ Hysterectomy _____ Other: _____

Date of Hysterectomy _____ Reason _____

Nursing History:

Were you breast fed (Y/N) _____ Are you lactating (Y/N) Start Date_____ Recent End Date:____

Pregnancies:

How many total: _____ Miscarriages/Abortions: _____ Full Term birth: _____ Pre-Term Births: _____

Month's nursed/Pumped for each child _____

Breast Information: Please all breast related information with dates and which breast

Event	Left	Right	Both	Date	Result/Complication
Trauma or Injury	____			_____	_____
Cyst aspirated	____			_____	_____
Biopsy	____			_____	_____
Augmentation	____			_____	_____
Reduction	____			_____	_____
Reconstruction	____			_____	_____
Other	____			_____	_____

Current Breast Symptoms (Circle Left, Right or Both) Please feel free to explain in detail.

Breast pain L –R- B _____

Tenderness L –R- B _____

Lumps L –R- B _____

Discharge L –R- B ____ Type _____

Anything else you would like to tell us about your breast? _____

_____

Referred By: _____

PLEASE CONTINUE ON OTHER SIDE

P.O. Box 891 - Knights Ferry, CA 95361 (209) 881-3044

THERMO-TECH INC.

BREAST THERMOGRAPHY INTAKE FORM

CONTINUED

Patient Name _____ **Client Number** _____

Environmental History

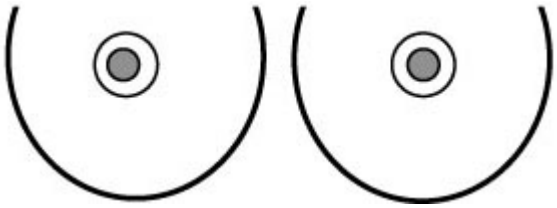
Hormone	Currently	Past No. Years
Natural	_____	_____
HRT	_____	_____
Thyroid	_____	_____
Birth Control pills	_____	_____
Other Hormones	_____	_____

Toxin Exposure: Type: _____ How long? ____
Amalgam Fillings: Number:_____ How long?____
Cigarette smoking now? _____ How long? _____
Cigarette smoking in pass? ___ How long? _____
Any other substance abuse? ___ How long?_____
Type _____

How is your health in general? (Circle) Good-Fair-Poor **Explain:** _____
Is there any other health concerns? _____

Do you get regular mammography? (Y/N) How many total? _____ Starting age? _____
Have you received a suspicious mammogram? _____ Date ____ Which breast? (Circle) Left Right Both
Result Description _____
Have you ever been diagnosed with cancer of any kind?
Diagnosis _____ Date _____ Breast Left Right Both _____
Description _____
Lymph Involvement _____ Other Organs _____
Treatment _____ Plans _____
Family History-Has any member of your family been diagnosed with cancer? Yes _____ No _____
If yes, whom and what type of cancer? _____
Have you ever had a Thermography? _____ Date and Results: _____

DIAGRAM OF PATIENTS BREAST (OFFICE USE ONLY)



Right Breast Left Breast

+++= Surgery # =Scars 0 = Lumps A or B =Aspiration/Biopsy ® = Reconstruction

I am aware that Nancy Gardner-Heaven TMT is not a medical doctor and cannot diagnose breast cancer. She is certified by the American Board of Thermology at Auburn University using the *Marseilles Classification* a proven scientific study for evaluating the thermal images with their corresponding rated of accuracy using the TH-1-TH-5 rating. This technique has been proven to have a 9% error rate for both false positive and false negative. I am informed that only a histology report can tell at 100% accuracy if a cell is malignant. All images taken in this study are the property of Thermo-Tech Inc. I will be provided a written report for my own use. If I have any complaints about this service or treatment, I agree to have a mediator resolve it and thus relinquish rights to trial. My signature below signifies my agreement with this contract.

Signature: _____ **Date** _____

My signature here is acknowledgement that I agree with the statement above in full as a waiver of my options for a trial.

P.O. Box 891 - Knights Ferry, CA 95361 (209) 881-3044