bras Thermography

Office Use Only
Payment: _____EMI #:_____
Scanned: _____DTBS:_____B/U:_____
Email: ____Mailed: _____Faxed:___

Name: _____ D.O.B. _____

Address: _____

City: _____ ST: _____ Zip: _____

Phone: _____(Home) _____(Cell)

E-mail: _____ Occupation: _____

How did you find out about us? _____

PLEASE READ THE FOLLOWING AND SIGN BELOW:

BRAS Thermography uses a Meditherm Digital Infrared Thermal Imaging camera to provide a 15-minute non-invasive test of physiology. DITI detects the minute physiologic changes that accompany breast pathology.

I understand that BRAS Thermography does not provide a medical diagnosis, but simply acts as the clinical Thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to BRAS. This evaluation may suggest further medical testing. If further testing is suggested I will consult my physician or health care provider. A doctor to doctor consultation can be arranged between Meditherm and your doctor if necessary.

I give my permission for the Clinical Thermographer at BRAS to take and submit DITI pictures for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that a copy of the report with images will be mailed or emailed to me so that I can share it with my health care practitioner or primary care doctor.

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition 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 statements above and consent to the examination.

Patient Signature _____Today's date _____

Physician's Name: _____Referred___ Send report ___

Thermographer's Signature_____ Date_____

All Clinical Thermographers
are trained and certified by the ACCT.

Patient Name: _____ **DOB:** _____

Please indicate <u>current</u> condition/treatment (3-month waiting period)

Breastfeeding	○ Yes	○ No
Pregnancy	○ Yes	○ No
Radiation treatment	○ Yes	○ No
Chemotherapy	○ Yes	○ No
Surgery/biopsy (screening area)	○ Yes	○ No

Please indicate if you've had a Covid-19 vaccine within last 4 weeks (4-week waiting period prior to first thermogram)

Recent Covid-19 vaccination	○ Yes	○ No

Significant Past Illnesses:

Illness	*Year(s)*	*Comments*

Previous Surgery:

Type of Surgery	*Year(s)*	*Comments*

Present Health Problems *(please indicate current concerns and/or symptoms)***:**

Medical Problem	*Date of Onset*	*Comments/Concerns/Symptoms*

Present Medications:

Medication Name	*Taken For*	*Date Started*

Patient Name: _____

Family Medical History:

	Age if Living	Age at Death	Cause of Death	Major Medical Health Problems (Bubble in all that apply)
Mother				○ Breast Cancer ○ Cancer ○ Stroke ○ Heart Attack/MI ○ Hypertension ○ Other (specify):_____
Father				○ Breast Cancer ○ Cancer ○ Stroke ○ Heart Attack/MI ○ Hypertension ○ Other (specify):_____

Do you participate in regular *(annual/bi-annual)* dental visits? ○ Yes ○ No
Any major dental work?_____

General overall health currently: ○ Excellent ○ Good ○ Fair ○Poor
If *fair* or *poor*, please explain: _____
_____
_____
_____
_____

Other Current Treatments: _____
_____
_____
_____
_____

Have you had any cosmetic fillers (i.e.: Botox, Restalyn, etc.) in the past 12 months?:
○ Yes ○ Never ○ Not in last 12 months

Have you ever had a thermographic scan? ○ Yes ○Never ○ Not in last 12 months
If yes, please tell us when and with whom. There is a possibility we can access your past report for comparison.
_____
_____
_____
_____

Patient Name: _____

Have you recently had any of these breast symptoms?	*Right Breast*	*Left Breast*
Pain		
Does pain subside after menstrual cycle ends		
Tenderness		
Does tenderness subside after menstrual cycle ends		
Lumps		
Change in breast size		
Does change in breast size subside after menstrual cycle ends		
Areas of skin thickening or dimpling		
Secretions of the nipple		

Breast Thermography Confidential Questionnaire

Please answer all questions	*Yes*	*No*
1. Do you have any close relative who has had breast cancer? Whom? _____		
2. Have you ever been diagnosed with breast cancer?		
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?		
4. Have you had any biopsies or surgeries to your breasts?		
5. Have you had any breast cosmetic surgery or implants?		
6. Have you had a mammogram in the past 12 months?		
7. Have you had a mammogram in the past 5 years?		
8. Have you had abnormal results from any breast testing?		
9. Have you ever taken a contraceptive pill for more than 1 year? If yes, are you still taking a contraceptive pill? _____		
10. Have you suffered with cancer of the womb?		
11. Have you had pharmaceutical hormone replacement therapy?		
12. Do you have an annual physical examination by a doctor? Does this include a gynecological exam?_____		
13. Do you perform a monthly breast self-exam?		

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. Date of last mammogram _____
17. How many births have you had? _____ **Your** age at the birth of your first child? _____
18. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____
19. Had vaccination in past 4 weeks? Indicate which arm. Left Arm___ Right Arm___ No___
20. Smoker status? ○ Yes ○ Never ○ Not in last 12 months ○ Not in last 5 years

Patient Name: _____

Extended Breast Questionnaire

Have you ever been diagnosed with breast cancer? Yes _____ No_____

Type of Cancer	***Date of Dx***	***Presently Being Treated***
Metastatic	Mo Yr	
Local	Mo Yr	
Lymph node involvement	Mo Yr	

Where on the breast *(upper outer, upper inner, lower outer, lower inner)***:**

Left Breast	UO	UI	LI	LO
Right Breast	UO	UI	LI	LO
Treatment	Surgery _____	Chemo _____	Radiation ___	None _____

Diagnosed with breast disease: Yes____ No____ *If yes, please check **Type of Disease** below:*

Fibrocystic ___	Cystic _____	Mastitis _____	Abscess _____	Other_____

Breast biopsies or surgery *(upper outer, upper inner, lower outer, lower inner)***:**
Date of biopsies or surgeries:_____

Left Breast	UO	UI	LI	LO	Nipple
Right Breast	UO	UI	LI	LO	Nipple

Please explain any past or current treatment for breast disease:_____
_____
_____

Authorization to Use or Disclose Protected Health Information

BRAS SE MO, LLC. dba BRAS Thermography

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, ***BRAS Thermography,*** **may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**
For the specific purpose of (*describe in detail*): **Interpretation of said images**

Effective dates for this authorization (today's date) _____/_____/_____ . This authorization will expire at the end of 10 days.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance in the use or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient's Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Patient or Patient's Authorized Representative *Date*

_____ _____

Authorized Signature of Facility *Date*