What To Do Before Your Scan: Breast

Client Information

Breast Screening with Infrared Thermal Imaging

Client preparation:
Complete all paperwork prior to your arrival. If you have questions, call Teresa Lopez at 561-881-4321. If this is not possible, arrive 15 minutes early for your appointment and complete the necessary paper work at that time. All information is confidential and is used to evaluate your thermal images.

- Avoid a hot shower at least 4 hours prior to exam.
- Do not smoke for 2 hours before the exam.
- Avoid caffeine beverages on the day of the exam.
- Do not use lotions or powder on your breasts on the day of exam.
- Avoid application of deodorant if possible.
- Do not shave or pluck any hairs on the day of the exam to avoid skin abrasions.
- Avoid any rough contact to the breast 24 hours prior to the exam.
- Avoid sun exposure for extended periods of time the day before and on day of the exam.
- Please provide a list of medications either prior to or at the time of exam.
- Notify the technician if you are taking Beta Blockers; if so, ask your doctor if you can hold that day's dose until after your scan.

You will need to disrobe from the waist up and acclimate to room temperature for 15 minutes prior to your scan. The scan will take approximately 30 minutes.
If you are disabled or unable to sit or stand for long periods, notify the scheduling technician. Complete testing requires your cooperation to image all areas effectively.

Test Results:
Once your scan is complete- you will receive your results before you leave.

Your scan results will include a re-call period from 3 to 12 months.

You are welcome to bring a companion or partner to be present during the exam. It is non-invasive and non-contact. The total time necessary to complete the procedure is approximately 45 minutes.

Infrared Imaging increases 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: Monthly self-examination, Annual physician examination, Annual Thermal Imaging and Mammography as indicated. Ask your health care provider for additional information.

Client Signature:____________________ Date:____________________ Tech Initial:_____
Date:__________

BREAST HEALTH QUESTIONNAIRE

FIRST NAME ____________________ LAST NAME ____________________ DATE OF BIRTH ___/_____/19____ Age __

ADDRESS ________________________________ CITY ________________________ ST______ ZIP__________

Phone Number________________________________ Fax Number ________________________

MEDICATIONS Have you ever taken BC pills: Yes___ No ____ Age started ____ Years taken _________

Are you currently taking Birth Control Pills: Yes ___ No __ Age started ____ Years taken ________

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 (type) of Progesterone: Prescriptive ____ Natural ____ Oral ____ Cream _____

Other drugs: List (i.e. blood pressure medication, etc.) ______________________________________

List supplements ____

RELEVANT HISTORY

GENERAL INFORMATION TO CALCULATE RISK INDEX

Menstrual day no. _______ Total days in cycle _______ Age Started ___________

Menopause age started: _______ Hysterectomy: Yes __ No __ Age ______ Ovaries removed: Age ______ Ovary R__ L___

No. of Pregnancies _____ Age at 1st Preg. _______ No. of Live Births ______ No. of children nursed more than 1 mo. ____

Are you Caucasian ___ African American ____ Asian American ____ Native American ______ Jewish _______ Other _______

LBS Overweight: 1 -20 lbs ____ 20– 40 lbs ____ 40 - 60 lbs ___ 60 + lbs ____

Have you experienced ANY blunt trauma to the chest: Yes _____ No _____ Year _______

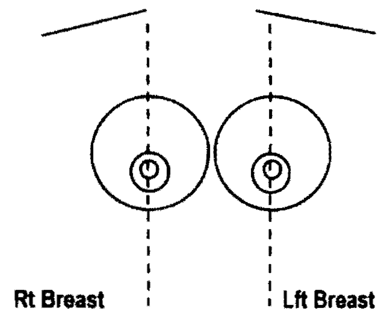
Do you consistently use anti-perspirants ?____________________

FAMILY HISTORY OF BREAST CANCER

Self _____ age _____ Mother ____ Sister ______ Daughter ________

Maternal grandmother _______ Maternal aunt ______ Maternal cousin ______

Paternal grandmother ________, Paternal aunt_______, Paternal cousin ________



NOTES

Physical Exam: Note by letter on the diagram the region of the breasts if affected by any of the following:

A Mass	B Thickening	C Discharge
D Nipple Change	E Skin change	F Area of pain
G Burning	H Tender	I Dull ache
J Sharp pain	K Implants	

Have you ever had a biopsy: Yes____ No _____ How many ____

Needle biopsy ____ Surgical biopsy_____ L____ R____ Position________ Year______

Were you told is was: Benign _______ Suspicious _______ Malignant _________

Lumpectomy : Yes __ No __ R _________ L _____________ Year of surgery _______

Mastectomy: Yes ___ No __ R _________ L _____________ Year of surgery ______

Radiation to breast: Yes ____ No ____ R ___________ L ____________ Month: ________ Year: ______

Chemotherapy: Yes _____ No ____ Month: ______ Year: ______

Date of last thermal image _______ **Date of last mammography exam**______ **Date of last breast ultrasound**________

Normal _____ Abnormal ______ Normal _____ Abnormal ______ Normal _____ Abnormal ______

Client Temperature _________ **Room Temperature** ___________

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

Patient's Name :____

Signed :____ Technician Initial ________

Date : ____ Date: ________________