Dr. Iris Rosenfeld Laguna Hills, CA 949-380-7215

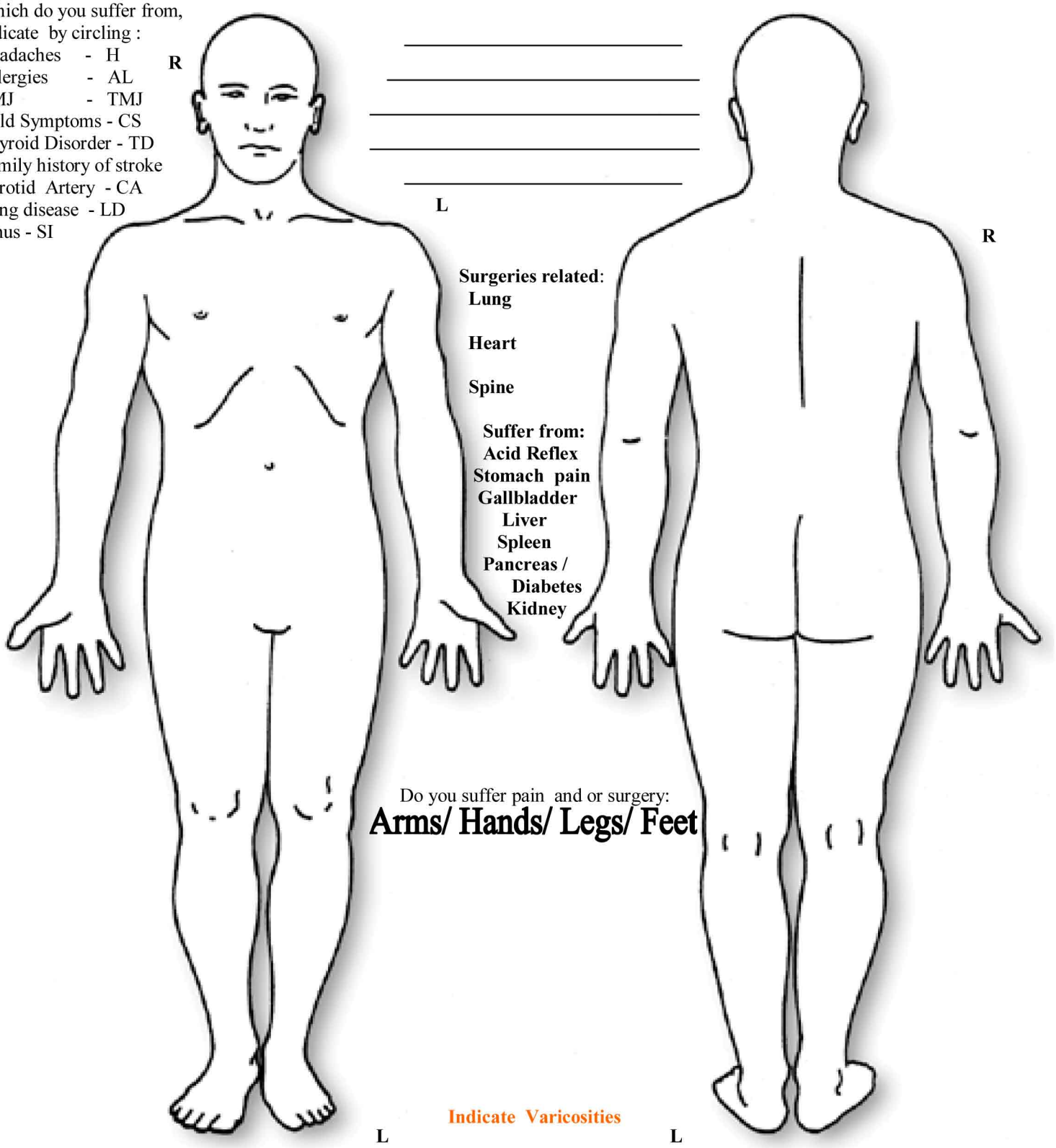
Name: _____ Today's date: _____

All information given in this questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify

Pain indicated by a line/ X if numbness indicate N , Scale 1 2 3 4 5 6 7 8 9 10 level of pain 10 is severe pain
Note : Scars from injuries / surgeries indicate an S and line of scar pattern , moles an M and fractures an F

Arm dominance: left handed / right handed

Which do you suffer from, indicate by circling :
Headaches - H
Allergies - AL
TMJ - TMJ
Cold Symptoms - CS
Thyroid Disorder - TD
Family history of stroke
Carotid Artery - CA
Lung disease - LD
Sinus - SI



Surgeries related:
Lung
Heart
Spine

Suffer from:
Acid Reflex
Stomach pain
Gallbladder
Liver
Spleen
Pancreas / Diabetes
Kidney

Do you suffer pain and or surgery:
Arms/ Hands/ Legs/ Feet

Indicate Varicosities

Surgeries related: _____

When was your last thermal: / /

I was referred by: _____

Name: _____ Birth Date: _____

Mailing Address: _____

E-Mail: _____ Home Ph. # _____ Cell Ph.# _____

Emergency Contact: _____ Home Ph.# _____

Format you desire to receive your report : In person by appointment / Mail / E-Mail

Room Temperature: start ° C / F

end ° C / F

Breast Questionnaire

(Circle Yes/ No with Clock positions on positive findings)

1. Do you have any close relative that has breast cancer? → Yes No If yes, Relationship:
2. Have you ever been diagnosed with breast cancer? → Yes No → If yes, type Metastatic / Lymph node / Local
3. Have you ever been diagnosed with any other breast disease ? Yes No When:
   _____ Where: Right : : Left : :
4. Have you had any biopsies to the breasts and your findings? Yes No → If yes, findings: fibrocystic / calcium nodule
   _____ When:
   Where: Right: : Left: :
5. Have you had breast cosmetic surgery or implants? → Yes No
6. Have you had a mammogram in the last 12 months? → Yes No
7. Have you had a mammogram in the last 5 years? → Yes No
8. How many mammograms had you had in total? Total # _____
9. At what age did you have your first mammogram? Age #_____
10. Have you ever taken a contraceptive pill for more then 1 year? → Yes No
11. Have you suffered cancer from the womb? → Yes No
12. Have you had pharmaceutical hormone replacement therapy? → Yes No
13. Do you have an annual physical examination by a Doctor? → Yes No
14. Do you perform a monthly breast self examination ? → Yes No
15. How many births have you had? Total# _____
16. What was your age when your first child was born? Your Age#_____
17. Did your menstrual periods start before the age of 12? → Yes No
18. Did your menstrual periods stop after the age of 50? → Yes No
19. Do you smoke? Yes No How long? ___ Number packs per day?_____
20. Have you had any of these breast symptoms in the last 6 months?_____

	Yes	No			
Pain	Y	N	Left	Right	Both
Tenderness	Y	N	L	R	B
Lump(s)	Y	N	L	R	B
Change in breast size?			L	R	B
Area of skin thickening or dimpling?			L	R	B
Secretion of the Nipple?			L	R	B

Previous Illness?_____

_____

_____

Previous surgeries?_____

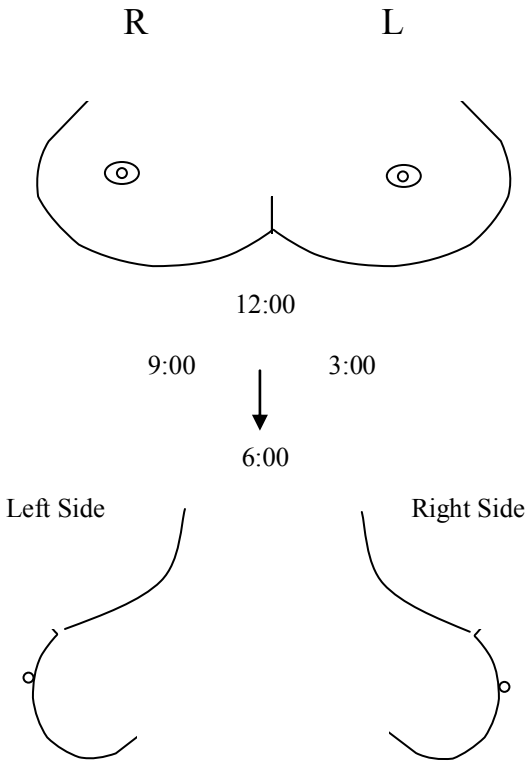
_____

Current Health Problems?

_____

Current medications? _____

_____



Patient Disclosure

I understand the report generated by my images is intended for use by trained health care providers to assist in evaluation, analysis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis , or treatment. I understand the report will not tell me whether I have an illness, disease, or other conditions but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the report. By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information and the receipt of information in the pursuit of comprehensive evaluation and treatment relating to the services provided by Sherri Curcie, CTT and/or Diane Wendell, ND, C.N.M. I further authorize direct payment of services to Nutrition Plus Wellness Center.

Patient Signature: _____ *Date:* _____