

## **Confidential Questionnaire**

## Head, Neck, Thyroid

Name	Birth Date	Today's Date		
Address	City	State	Zip	
Phone Number (home)(cell	lular)	(work)		
E-Mail Address	Referring Phys	sician		
All information given in the questionnaire will remain thermologist and any o			ed to the re	porting
			Yes	No
1. Do you suffer with headaches?  If yes, ○ once a month or less ○ more that	an once a month		0	Ο
2. Do you have known allergies? Food	Environmental		0	0
3. Do you have TMJ or does your jaw click?			0	0
4. Do you currently have a cold?			0	0
5. Are you being treated for a thyroid disorder?	Type		Ο	0
6. Do you have neck pain?			Ο	0
7. Do you have upper back pain?			Ο	0
8. Do you have a known history of carotid artery	disease?		Ο	0
9. Do you have a family history of stroke?			Ο	0
10. Do you currently suffer with sinus problems	?		0	Ο
Do you have any special concerns or are there any	y details related to	the information abo	ove?	
<b>Procedure:</b> 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.				
Patient Disclosure: I understand that the report generated provider to assist in evaluation and treatment. I further un self-evaluation or self-diagnosis. I understand that the report conditions, but will be an analysis of the images with respective.	derstand that the repo ort will not tell me whe	rt is not intended to be ether, I have any illnes	used by my s, diseases,	yself for or other
By signing below, I certify that I have read and understand	the statement above a	nd consent to the exan	nination.	
Patient Signature_		Today's Date		