Patient Update Form

Mend Thermography
(515) 207-4803

Date filed _____

Patient Information

Name _____ Age _____ DOB ____/____/___ Gender: ☐ Male ☐ Female

Address _____ City, State, Zip _____

Phone _____ E-mail _____

Preferred method of communication: ☐ Any ☐E-mail ☐Text ☐ Call—may we leave a message? ☐ Yes ☐No

Marital Status: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single

Emergency Contact: _____

Relationship _____ Phone _____

Primary Care Physician_____

We typically send reports via secure email. Please indicate if you prefer another method:

☐Office Pick-up ☐Mail (+$3.99)

Health Information

Clinical Concerns _____

Current Symptoms _____

Current Treatments: ☐Chiropractic ☐Massage Therapy ☐Acupuncture ☐Physical Therapy

☐ Others (please list):_____

Current Prescription Medications & Over the Counter Medications ☐ None ☐ No change ☐ Yes (list below)

_____ _____ _____

Medical Diagnoses? _____

Health Histories

Mammogram/Ultrasound History

Date of last mammogram? _____ Any noted abnormalities? ☐ No ☐ Yes

If yes, please explain: _____

Thermogram History

Any noted abnormalities on thermogram? ☐ No ☐ Yes, explain _____

Did you seek further testing? ☐ No ☐ Yes If yes, what type of test and what was the result? _____

_____

Any changes since your last visit? *(explain)*

Surgical: ☐ No ☐ Yes _____

Dental: ☐ No ☐ Yes _____

General History: ☐ No ☐ Yes _____

Family Health History: ☐ No ☐ Yes _____

OBGYN: ☐ None ☐ Cervical Cancer ☐ Hysterectomy ☐ Ovarian Cysts ☐ Uterine Cysts ☐ Endometriosis ☐ Other

Explanation and date(s) _____

Breast Thermography Confidential Questionnaire

Name: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____

Email: _____ Phone: _____ Doctor: _____

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

Please mark Yes or No as it applies to you:	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
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?	☐	☐
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?	☐	☐
13. Do you perform a monthly breast self-exam?	☐	☐

14. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____
15. How many mammograms have you had in total? _____
16. What was your age when you had your first mammogram? _____
17. How many births have you had? _____ Your age at birth of first child: _____
18. Do you smoke? Yes ☐ Never ☐ Not in last 12 months ☐ Not in last 5 years ☐
19. Had a vaccination in last 4 weeks? Indicate which arm? Left ☐ Right ☐ No ☐

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

Patient Disclosure:

I understand that the Report generated from my images is intended for use by trained healthcare 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 an 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.

Signature_____ Date_____

Informed Consent for Thermography

Please read carefully and sign below if you are in agreement with this consent form. Please ask questions if there is anything that you do not understand on this consent form.

I understand:

- Thermography is simply a procedure utilizing thermal imaging cameras to visualize and obtain an image of the infrared radiation (heat) coming from the surface of the skin. The Thermographic procedure is performed as an aid to the evaluation of abnormal temperature patterns which may or may not indicate the presence of a disease process.
- A thermogram is not a stand-alone diagnostic tool. It is an adjunctive tool, which while reliable, should be used by the primary care physician along with other diagnostic tests and analyses to arrive at a provisional or more complete diagnosis. No surgical procedure should be based on thermography alone.
- Thermography is not a replacement for any anatomical imaging tests (mammography, ultrasound, CT, MRI, etc.). Results of your thermogram may require further investigation by one or more of these tests.
- I will be disrobed relevant to the area of study to allow the surface of my body to cool to an ambient room temperature. I will then be examined with a digital infrared thermal imaging camera by a certified thermographer.
- My images will be interpreted by a board-qualified or board-certified thermologist from Electronic Medical Interpretation Inc. This report will only be an analysis of the thermographic findings and will not be a guarantee that an illness, disease, or condition is present or absent.
- It is my responsibility to provide my health care provider with my report for further diagnosis and analysis in the overall evaluation of my health. Thermography is not a replacement for medical care, and I intend to remain under the care of my primary healthcare provider.
- I have been given a patient preparation form to ensure the most accurate thermographic evaluation possible. I have informed the thermographer of any skin lesions, bruises, wounds, etc. that may cause changes in my thermographic images.
- I am responsible for my own decisions regarding my health, wellness, and nutrition. Therefore, MEND Thermography cannot be held responsible for any decisions I make. MEND Thermography is not responsible for any supplements/care products I use or purchase through their store or online dispensary. I understand that I should talk with my physician before using any supplements or making lifestyle changes.
- I am aware that this procedure is not covered by insurance and that the office fee is due and payable at the time of service unless special provisions have been made with the office in advance.
- MEND Thermography will keep my information confidential unless I provide a written release or as required by law (HIPAA).

By signing below, I certify that I have read and understand the statements above, I have received satisfactory answers to all questions I may have had, and I consent to the thermographic examination.

Patient Signature: _____ Date: _____

Printed Name of Patient: _____

Authorization to Use or Disclose Protected Health Information

MEND Thermography

Patient Name**:** _____

Address: _____

Date of Birth: _____ Date of Request**:** _____

As required by the Privacy Regulations, MEND 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: _____/_____/_____ through _____/_____/_____

This authorization will expire at the end of the above period.

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

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

_____ _____
Authorized Signature of Facility *Date*