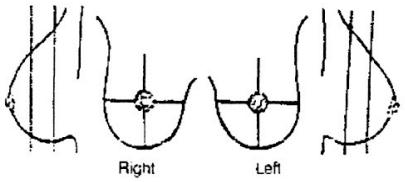
Southwest Medical Thermal Imaging & Ultrasound, LLC

BREAST ULTRASOUND QUESTIONNAIRE

PATIENT NAME:_____DOB:_____

ID/REPORT # (office use)_____

YES	NO	
○	○	1. Are you pregnant?
○	○	2. Do you have a family history of breast cancer? Age at Diagnosis:_____ (Self, Mother, Sister, Grandmother, Aunt or Daughter)
○	○	3. Have you had a mammogram before? Approximate date:_____
○	○	4. Have you had any areas of risk identified with thermography?
○	○	5. Are you or your doctor feeling any lumps in your breasts now? If yes, please diagram the location on the drawing.



			LEFT	RIGHT
○	○	6. Are you having any of the following symptoms?		
			☐	☐ Palpable lump or thickening
			☐	☐ Bloody discharge
			☐	☐ Non-bloody discharge
			☐	☐ Skin thickening or dimpling
			☐	☐ Nipple abnormality
			☐	☐ Pain
			☐	☐ Other:_____

			LEFT	RIGHT	DATE
○	○	7. Previous Breast Procedures?			
		a. Cyst aspiration	☐	☐	_____
		b. Biopsy, needle	☐	☐	_____
		c. Biopsy, surgical	☐	☐	_____
		e. Mastectomy	☐	☐	_____
		f. Radiation treatment	☐	☐	_____
		g. Implants	☐	☐	_____
		h. Silicone injections	☐	☐	_____
		i. Breast reduction	☐	☐	_____
		j. Other:_____	☐	☐	_____

○	○	8. Are you currently taking Hormones? If so, please circle: (Birth control pills, Estrogen or Progestin) Number of years?_____

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 sonographic findings discussed in the report. Ultrasounds are not a replacement for mammograms. By signing below, I certify that I have read and understand the statements above and consent to the examination.

PATIENT SIGNATURE:_____ DATE:_____

SWMTIU SIGNATURE:_____ DATE:_____