DITI IMAGING
DIGITAL THERMOGRAPHY

Upper Body Study Questionnaire

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.

Name: _____ **D.O.B:** _____

Address: _____

Phone: _____ **Your Doctor:** _____

Please Show areas of:

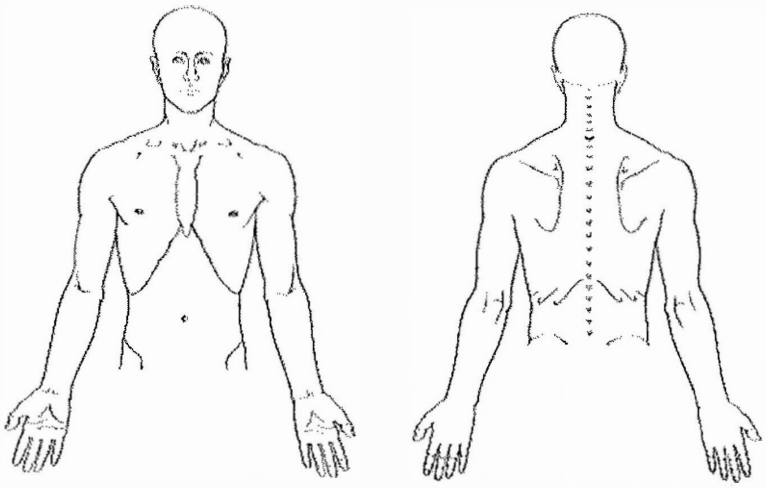
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring ↗



Do you know what triggered the pain ? _____

Does anything relieve it ? _____

Does anything aggravate it ? _____

Has it changed since it began ? _____

Have you had any treatment ? _____

History: Injuries / Fractures / Surgery :

_____

_____

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 thermographic findings of the areas 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:** _____

Upper Body History

NAME:		**DOB:**
ADDRESS:		
EMAIL:		**PHONE:**
SEX:		**OCCUPATION:**

Primary concerns, complaints, symptoms today:

History: ***Please provide basic information in chronological order by year (approximate), regarding any significant accidents, injuries, surgeries, diagnosis, dental work, etc.***

Example: ***1995 - car accident, whiplash, no treatment required.***
1998 - complete hysterectomy
2001 - diagnosed with hyperthyroidism

Accidents/Injuries/Concussions:

Surgeries (including dental & cosmetic):

Diagnoses:

Current prescription medications:

Signature **Date**

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Name: _____ **Birthdate:** _____

Address: _____ **City** _____ **Zip** _____

Email: _____ **Phone:** _____

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Breast Thermography Confidential Questionnaire

	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 non-cosmetic 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 oral contraceptives for more than 1 year?	☐	☐
10. Have you been diagnosed with uterine cancer?	☐	☐
11. Have you ever used any type of hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

14. Approximately how many mammograms have you had? _____

15. What was your age when you had your first mammogram? _____

16. How many children have you given birth to? _____ Your age at birth of first child? _____

17. Did your periods start before the age of 12? _____ Or finish after the age of 50? _____

18. Do you smoke? Yes: ☐ Never: ☐ Not in last 12 months: ☐ Not in last 5 years: ☐

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	☐	☐

Reason for screening today: _____

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 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:** _____

Understanding of Services Provided
By DITI Imaging

I _____ fully understand the following:
(Please Print Your Name)

- DITI Imaging does **NOT** diagnose or treat any disease or health condition. If I have any disease or abnormal health condition, I must seek qualified medical advice from a licensed physician.
- DITI Imaging is dedicated to help their clients find a path to better health with an emphasis on education and self-care. My interest is to educate myself in achieving the best health possible.
- Digital Infrared Thermal Imaging (DITI) is an **adjunctive screening** and is not designed to replace current screening methods.
- Digital Infrared Thermal Imaging, like a mammogram or sonogram, is not 100% effective. A suspicious mass may warrant a biopsy.
- I have chosen to have this type of screening procedure for one or more of the following reasons:
  (initial those that apply)

  _____ I wish to minimize my exposure to radiation.
  _____ I am looking for methods of possible earlier detection of any abnormalities.
  _____ I do not desire to have a mammogram.
  _____ I have had a mammogram before and chose not to have another.
  _____ I have had a mammogram and desire to use this procedure in between checkups.
  _____ _____

- DITI is appropriate for **ALL** women, but especially for younger women between 25 and 50 whose denser breast tissue makes it more difficult for a mammogram to pick up suspicious lesions. This can provide a "clinical marker" to the doctor or mammographer that a specific area of the breast needs particularly close examination.
- What I learn from DITI Imaging and this procedure may not be universally accepted. Certain agencies and other health authorities may not agree with an approach where the client must be responsible for developing and maintaining their own health.
- The reports/images provided are **NOT** designed for self-diagnosis and should be reviewed with a Health Care professional.

I have read and understand what is printed above.

Signature _____ Date _____

☐ I would like a copy of my report ***emailed*** to me at: _____

OR:

☐ I would like a copy of my report ***mailed*** to me:

Address _____

City _____ State _____ Zip code _____

☐ I would like a copy of my report ***mailed*** to my Doctor:

Doctor's name _____

Address _____

City _____ State _____ Zip code _____

I may be reached at the following numbers:

Home: _____ Office: _____

Cell: _____ Other: _____

How did you hear about us? _____

Authorization to Use or Disclose Protected Health Information

DITI Imaging

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Date: _____

As required by the Privacy Regulations, *DITI Imaging* 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 _____/_____/_____
(today's date) (one year from today)
This authorization will expire at the end of one year unless otherwise requested.

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*

DITI Imaging

Cancellation and Reschedule Policy

- We understand that life happens and sometimes you are unable to keep your scheduled appointment. In these instances, we would greatly appreciate your courtesy call at least 24 hours in advance of your appointment time, so that we can plan accordingly. This consideration allows other patients an opportunity to reserve an appointment during that time. Because of the distance that we often travel to provide service to our remote clinics, your advance notice also assures that we plan our staffing and materials requirements properly.

- If you do not appear for your scheduled appointment and you have not contacted us via phone (as we do not accept cancellations by email), we reserve the right to charge a $50 cancellation fee.

- If you are running late for your appointment, please call us. We will do our best to accommodate you or reschedule your appointment.

We are dedicated to making your screening appointments as easy and convenient as possible. We thank you for your understanding of this important issue.

_____

Patient Name (*please print)*

_____ _____

Patient Signature Date

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