## **Confidential Questionnaire**

## Men's Health Screening Body

| name  | Birth Date   | Today's I | Date          |         |  |
|---|--|-----------|---------------|---------|--|
| Address   | City   | State     | Zip_          | Zip     |  |
| Phone Number (home)                                       | (cellular)   | (work)    |               |         |  |
| E-Mail Address  |  |           |               |         |  |
| Referring Physician                                       |  |           |               |         |  |
|   | ionnaire will remain strictly confidential a<br>mologist and any other practitioner that y |           | ged to the re | porting |  |
| Head & Neck   |  |           | Yes           | No      |  |
| 1. Do you suffer with headaches If yes, o once a month or | ? less o more than once a month  |           | 0             | 0       |  |
| 2. Do you have allergies? Foo                             | od Environmental   |           | 0             | 0       |  |
| 3. Do you have TMJ or does you                            | ır jaw click?  |           | 0             | 0       |  |
| I. Do you currently have a cold?                          |  |           | 0             | 0       |  |
| 6. Are you being treated for a th                         | yroid disorder? Type   |           | 0             | 0       |  |
| 6. Do you have neck pain?                                 |  |           | 0             | 0       |  |
| 7. Do you have upper back pain's                          | ?  |           | 0             | 0       |  |
| B. Do you have a history of caro                          | tid artery disease?  |           | 0             | 0       |  |
| O. Do you have a family history                           | of stroke?   |           | 0             | 0       |  |
| 0. Do you currently suffer with                           | sinus problems?  |           | 0             | 0       |  |
| 11. Do you have history of denta<br>Root canals Gum di    | al problems?<br>sease Implants   |           | 0             | 0       |  |
| Non-replaced extractions                                  | Dentures   |           |               |         |  |
| 12. Have you had dental cleaning                          | g in the past 7 days?  |           | 0             | 0       |  |
|   |  |           |               |         |  |

## Chest, Heart & Lungs

| 1. Have you been diagnosed with:  |                        | Yes | No |  |
|---|------------------------|-----|----|--|
|   | Heart disease?         | 0   | 0  |  |
|   | Lung disease?          | 0   | 0  |  |
|   | Upper spine disorders? | 0   | 0  |  |
| 2. Do you suffer with upper back pa   | in?                    | 0   | 0  |  |
| <ul><li>3. Do you suffer with chest pain?</li><li>4. Have you ever had surgery to you</li></ul> | ır:                    | 0   | 0  |  |
|   | Heart?                 | 0   | 0  |  |
|   | Lungs?                 | 0   | 0  |  |
|   | Mid to upper back?     | 0   | 0  |  |
| 5. Do you have asthma or shortness of breath?   |                        |     | 0  |  |
| 6. Do you currently smoke?  |                        | 0   | 0  |  |
| 7. Have you smoked in the past 5 years?   |                        |     | 0  |  |
| Do you have any special concerns or are there any details related to the information above?     |                        |     |    |  |
|   |                        |     |    |  |

## Abdomen & Lower Back

|   | Yes      | No  |                                   | Yes    | No |
|---|----------|-----|-----------------------------------|--------|----|
| <ol> <li>Do you suffer with acid reflu</li> </ol> | x or oth | ner | Have you had surgery or disease i | n the: |    |
| digestive problems?                               | 0        | 0   |                                   |        |    |
| 2. Do you suffer pain in the:                     |          |     | Stomach?                          | 0      | 0  |
| Stomach?  | 0        | 0   | Spleen(Upper Left)?               | 0      | 0  |
| Below R Breast?                                   | 0        | 0   | Liver(Upper Right)?               | 0      | 0  |
| Below L Breast?                                   | 0        | 0   | Kidneys?                          | 0      | 0  |
| Abdomen?  | 0        | 0   | Intestines ?                      | 0      | 0  |
| Lower Back?                                       | 0        | 0   | Abdomen?                          | 0      | 0  |
| Pelvic Region?                                    | 0        | 0   | Lower Back?                       | 0      | 0  |
|   |          |     | Pelvic Region?                    | 0      | 0  |

| Have you consumed alcohol in the past 24 hours?   | 0   | 0 |
|---|---|---|
| Do you have any special concerns or are there any | details related to the information above? |   |
|   |   |   |
|   |   |   |

**Procedure:** 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 from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, 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 statement above and consent to the examination. |
|--|--|
|  |  |
| Patient Signature                                | Today's Date   |
| 1 attent Signature                               | Ioday s Datc   |