

Infrared Breast Imaging



Patient's Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Date of Birth: _____ Age: _____ Sex: _____

Have you ever been diagnosed with breast cancer? Y N Date: _____ R L Breast
Do you have a family history of breast cancer? If yes, who? _____

Date of your last mammogram: _____
Was it: Normal Abnormal Suspicious Watchful – R L Breast

Date of your last breast ultrasound: _____ Were both breasts imaged? Y N
Was it: Normal Abnormal Suspicious Watchful – R L Breast

Was a follow up biopsy recommended after your LAST mammogram, ultrasound, or MRI? Y N

Date of last breast exam by a doctor: _____ Normal Lump Thickening – R L

Any tests recommend after this last breast exam? (ex. mammogram) _____

Date of any breast biopsies: _____ R L Breast

What was found on the biopsy? Cancer Other _____ R L Breast

Any breast surgeries? Date and what was done? _____ R L Breast

Have you had a mastectomy? Complete Partial Date: _____ R L Breast

Was the nipple removed? Y N Was the surface skin of the original breast entirely removed? Y N

Any breast reconstruction? What was done? (ex. trans flap, implant) _____ R L Breast

Any breast radiation treatment? Date of last treatment _____ R L Breast

Are you currently pregnant? Y N Are you currently nursing? Y N

Are you CURRENTLY experiencing any of the following with your breasts: None

Lump Thickening (date found _____; found by Self breast exam Doctor exam)

Pain: Dull Sharp Burning Stinging Tenderness The pain changes with my cycle

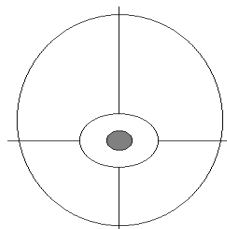
Thickening Skin changes (Color Texture Over the lump)

R L Nipple discharge (Bloody Milky Clear Through 1 duct Through multiple ducts)

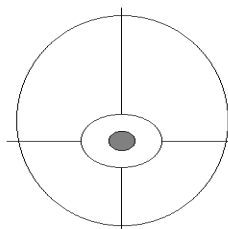
R L Nipple retraction (For many years Recently) R L Nipple changes (Color Texture)

Other _____

Place an [O] on the diagram in the exact area of the lump. [M] for a finding on your mammogram / ultrasound / MRI. [W] for an area being watched. [X] in the area of pain, tenderness, or skin changes. [#] in the area of thickening. [+++] in the area of scars



RIGHT



LEFT

Re-Exam

High T: _____ Low T: _____ Tech: _____

Pt T = _____ F Rm T = _____ C R L Nipple retraction R L Areola traction SLQ SMQ ILQ IMQ

R L Skin surface bulge or dimple SLQ SMQ ILQ IMQ R L Skin changes SLQ SMQ ILQ IMQ

R L Nipple changes (Color Texture) R L Nipple discharge (Bloody Milky Clear – S M)