Radiant Health Imaging Patient Intake Form

Name _____

DOB _____ Age _____

Street _____

Town _____

State, Zip _____

Occupation _____

E-mail _____

For office use only:

Patient ID# _____ Next Appt._____

Report Ref # _____ BR1 BR2 BRA HB FB ROI

Referred by _____

Location _____ Scans uploaded_____

Data updated _____ called _____

RC___ Pt rpt sent_____ HCP rpt sent _____

Pymt _____ ck #_____ V MC Disc Amx CD/Prt

Phone (please include area code) (H) _____ (W) _____

(C) _____ Leave message w/results? Yes / No

Reason for today's visit: _____

Current Symptoms: _____

_____

Current Treatment: _____

Current skin lesions/locations: _____

Health History:

Previous illnesses: _____

_____

Previous Surgeries/Dates: _____

Injuries/Dates: _____

Current Medication(s): _____

Do you want your report sent to your Health Care Provider? (circle one) Yes No

Providers name and address: _____

_____

This information is confidential. All information is correct to my knowledge.

Signature: _____ Date: _____

Breast Thermography Confidential Questionnaire

Name:_____ DOB: _____

1.	Do you have any close relative who has had breast cancer?	Yes	No
2.	Have you ever been diagnosed with breast cancer?	Yes	No
3.	Have you ever been diagnosed with any other breast disease (fibrocystic)?	Yes	No
4.	Have you had any biopsies or surgeries to your breasts?	Yes	No
5.	Have you had any breast cosmetic surgery or implants?	Yes	No
6.	Have you had a mammogram in the past 12 months?	Yes	No
7.	Have you had a mammogram in the past 5 years?	Yes	No
8.	Have you had abnormal results from any breast testing?	Yes	No
9.	Have you ever taken a contraceptive pill for more than 1 year?	Yes	No
10.	Have you suffered with cancer of the womb?	Yes	No
11.	Have you had pharmaceutical hormone replacement therapy?	Yes	No
12.	Do you have an annual physical examination by the doctor?	Yes	No
13.	Do you perform a monthly breast self exam?	Yes	No

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ 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__ No __ 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	☐	☐

Signature _____ Date _____

Authorization to Use or Disclose Protected Health Information

Radiant Health Imaging, Inc.

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, *Radiant Health Imaging, Inc.* 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, Inc.

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

Effective date for this authorization: _____

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*

Patient Preparation Sheet/Breast

Purpose of test:
For early detection of abnormal changes in the breasts requiring further diagnostic testing. A screening baseline cannot be acquired while pregnant or lactating (wait 3 mos post lactation)

Patient Preparation:
Prior to your appointment do not (on the day of):

- have physical therapy or electromyography
- use a tanning booth and avoid overexposure to the sun
- have strenuous exercise
- smoke for 2 hours
- shave your underarms or use lotions, powders, antiperspirants, therapeutic essential oils or makeup on the chest area
- do skin brushing
- have kidney dialysis

Do not have body work **2 days** prior. Do not have acupuncture treatment **3 days** prior. Wait **3 mos**. post surgery, radiation therapy, chemotherapy before scheduling appt. Wait **3 mos**. post lactation.
If your hair falls below your neck, please clip it up.
Attire – Loose fitting clothes and no jewelry around the neck.
No changes necessary for diet or medication.

General Information
Procedure is non-invasive, no-contact, private, no radiation.
Disrobing – remove all upper body clothing and jewelry. Put on a gown supplied. Inform your thermographer if you had any recent skin lesions on your breast; the inflammation may cause a false positive result.

Thermography is performed by a female certified clinical thermographer and is completely private.
There are no risks and no side effects.
Average time for the appointment is 30 minutes.
Please bring your healthcare provider's name and address if you want a copy of your report and scans mailed to him/her.
We gladly accept personal check, cash, Visa or MC for payment.

You are welcome to bring a companion to be present during the scan.