Elevation Thermography New Patient Paperwork
3600 W Eldorado Pkwy Bldg. C, Unit 4
McKinney, TX 75070 | 972-540-5333
TODAY'S DATE: ___________________

PATIENT INFORMATION

Name: ____ DOB: ________________ Age: ____ Gender: M/F

Address: ____ City: ____________________ State: ____ Zip code: __________

Mobile Phone: ______________________________ Email: ____

Have you previously had a thermography scan? YES/ NO If yes, where? ____

Emergency Contact Name: ______________________________ Number: __________________ Relationship: ___________

How did you hear about our office? ____

Current weight:________ Target weight:________

CONDITION INFORMATION

What are your current concerns/complaints? ____

____

____

____

Please mark the area on the diagram below using the following code:

N – Numbness

P – Pain

T – Tingling

A – Ache

S – Soreness

ST – Stiffness

Please mark any and all scars using the following:

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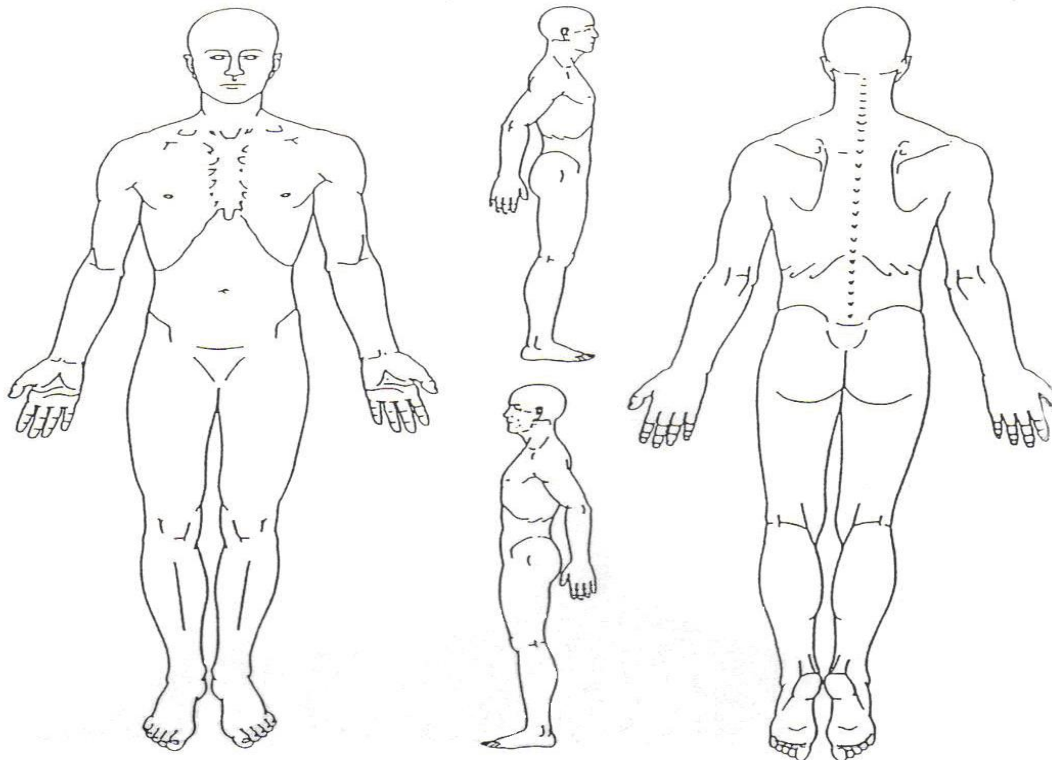


PATIENT HISTORY

Please circle yes or no for questions below:

Do you have any current diagnoses / diseases / conditions? YES / NO

List diagnoses / diseases / conditions: ____

____

Have you had any surgeries? YES / NO

List surgeries and dates: ____

____

Have you had any broken bones / fractures? YES / NO

List bones broken / fractures and dates: ____

____

Have you had any dental work in the past 2 months? YES / NO

Type of works and dates (give location – ex. rear upper molars): ____________________________

Have you had the flu, cold, COVID-19 or any other illness in the past month? YES / NO

If yes, what did you have? ____

Do you suffer from any condition other than that which has been listed previously? YES / NO

If yes, what is it? ____

Have you ever been diagnosed with cancer? YES / NO

Date: ________________ Type: ____

Do you have a family history of breast cancer? YES / NO

If yes, who? ____

Date of your last mammogram: ______________________________

Was it (circle one): NORMAL / ABNORMAL / SUSPICIOUS / WATCHFUL

Which breast (circle one): RIGHT / LEFT Breast

Date of your last breast ultrasound: ___________________________ Were both breasts imaged? YES / NO

Was it (circle one): NORMAL / ABNORMAL / SUSPICIOUS / WATCHFUL

Which breast (circle one): RIGHT / LEFT Breast

Was a follow-up biopsy recommended after your LAST mammogram, ultrasounds, or MRI? YES / NO

Date of last breast exam by a doctor: ____________________

Results (circle one): NORMAL / LUMP / THICKENING | RIGHT / LEFT Breast

Any tests recommended after last breast exam? (ex. mammogram) ______________________________

Date of any breast biopsies: ____ RIGHT / LEFT Breast (circle one).

What was found on the biopsy? (circle one): CANCER / OTHER ____________________ RIGHT / LEFT Breast (circle one).

Any breast surgeries? YES / NO

If yes, what was done? (ex. trans flap, implant): _________________________________RIGHT / LEFT Breast (circle one).

Have you had a mastectomy? (circle one): COMPLETE / PARTIAL / NONE Date: _______ RIGHT / LEFT Breast (circle one).

Was the nipple removed? YES / NO

Was the surface skin of the original breast entirely removed? YES / NO

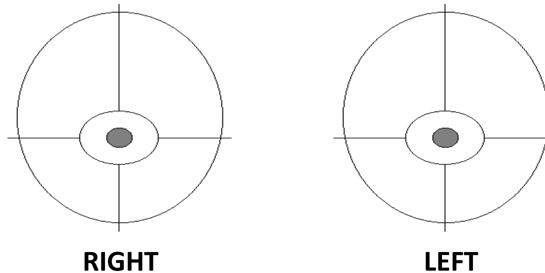
Any breast reconstruction? YES / NO
If yes, what was done? (ex. trans flap, implant): __________________________________RIGHT / LEFT Breast (circle one).
Any breast radiation treatment? YES / NO If yes, what was the date: _______________ RIGHT / LEFT Breast (circle one).

Are you currently pregnant? YES / NO
Are you currently nursing? YES / NO

Are you CURRENTLY experiencing any of the following with your breasts (circle all that apply)**:**

- LUMP (date found __________________; found by (circle one): SELF BREAST EXAM / DOCTOR EXAM)
- PAIN (Is your pain (circle one): DULL / SHARP / BURNING / STINGING / TENDERNESS / PAIN CHANGES WITH MY CYCLE
- THICKENING
- SKIN CHANGES (If yes, please circle all that apply): COLOR / TEXTURE / OVER THE LUMP
- RIGHT / LEFT Nipple Discharge (circle one): BLOODY / MILKY / CLEAR / THROUGH 1 DUCT / THROUGH MULTIPLE DUCTS
- RIGHT / LEFT Nipple Retraction (circle one): FOR MANY YEARS / RECENTLY
- RIGHT / LEFT Nipple changes (circle one): COLOR / TEXTURE
- NONE
- 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 any areas of pain, tenderness, or skin changes. [#] in any areas of thickening. [+++] in any areas of scars.



I have completed this form to the best of my ability.

Patient Signature: ____ Date: ____________________________

Office Use Only:

Tech: _________________________________ Room Temp: _______________

Re-Exam: YES / NO

PATIENT PREPARATION INSTRUCTIONS – ELEVATION THERMOGRAPHY

Before you arrive for your thermographic examination, certain protocols must be followed to ensure your images reflect accurate information. Please **read the following instructions** carefully and **adhere to them** as closely as possible.

- NO prolonged sun exposure to body areas being imaged **FIVE** days prior to exam.
- NO use of deodorants, lotions, creams, powders, facial makeup the **DAY OF** exam.
- NO shaving areas to be imaged **DAY OF** exam.
- NO treatment (chiropractic, acupuncture, TENS, physical therapy, electrical muscle stimulation, ultrasound, hot or cold pack use) or physical stimulation of areas to be imaged **24 HOURS** prior to exam.
- NO exercise **4 HOURS** prior to exam.
- If bathing, no closer than **1 HOUR** prior to exam.
- If using pain medications, please avoid taking them for **4 HOURS** prior to exam. **You must consult with prescribing physician for their consent prior to any change in medication use, such as this.**
- If nursing, please try to nurse as far from **1 HOUR** prior to exam as possible. **Nursing can greatly alter results.**
- Please **bring a hair tie** with you to the exam.

Please note: During the exam you will be disrobed (from waist up for the breast exams, and buttocks exposed for lower body exams) during part of the exam for both imaging and to allow for the surface temperature of the body to equilibrate with the room. A female technician is provided for all our female patients and a male technician for all male patients.

We have enclosed a health history form for you to be filled out before arriving for your exam. If you have copies of any other test results (i.e. mammograms, blood tests, etc.), please bring them with you. If you have any further questions, please contact our office at 972-540-5333.

Thank you for choosing Elevation Thermography and we look forward to meeting you!