

# MAXILLO-FACIAL INTAKE FORM

## Infrared Breast Health, LLC

102 Hodson Lane Eugene, OR 97404 (541) 302-2977 (541) 302-6565

CLIENT NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_ LAST FIRST

Address \_\_\_\_\_

NUMBER STREET CITY STATE ZIP CODE

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Name of Physician (if referred by) \_\_\_\_\_

Fax or Address (if results are requested) \_\_\_\_\_

### HEALTH EVALUATION

1. If a physician has EVER told you that you had one of the following disorders, please CIRCLE it and write the approximate date of the diagnosis to the listed disorder:

ANGINA BLOOD CLOTTING PROBLEMS CANCER DIABETES HIGH BLOOD PRESSURE HEART ATTACK

HIGH BLOOD CHOLESTEROL INTERMITENT CLAUDICATION PHLEBITIS THYROID DISORDER NEUROPATHY

MIGRANE OR CLUSTER HEADACHES RAYNAUD'S DISEASE STROKE (CVA) TIA (MINI STROKE) VARICOSITIES

2. Do you currently have any of these problems? Circle medical concerns if Yes.

Facial Pain Dental Pain Pain with Chewing Jaw Locking/Clicking/Popping TMJ Pain

Headaches Ear Pain Ear Noise Sinusitis Poor Hearing Problem with Vision

3. Have you EVER used tobacco in any form? YES / NO If yes, please give the approximate number of years you used tobacco \_\_\_\_\_, the approximate amount \_\_\_\_\_ packs / day you used and the \_\_\_\_\_ years since you quit.

4. Has a first-degree relative (Father, Mother, Sister, or Brother) had a heart attack or stroke before age sixty?

YES / NO If yes, who (details)? \_\_\_\_\_

\_\_\_\_\_ How old were they \_\_\_\_\_ and are they living now? YES / NO

5. Have you EVER had ANY surgery to your HEAD NECK CHEST ARMS LEGS? YES / NO If yes, please provide the date and description of the surgery. \_\_\_\_\_

6. Please list ALL PRESCRIPTION DRUGS that you have taken in the past three (3) months.

## Consent to Infrared Imaging / Thermography

Infrared Breast Health, LLC.  
1102 Hodson Lane, Eugene, OR 97404  
Tel: 541-302-2977 Fax: 541-302-6565

**Instructions:** Please read the following carefully and initial your name on the line at the end of each section.

I understand that thermography is a procedure utilizing infrared imaging cameras to visualize and obtain an image of the infrared heat coming off the surface of the skin. The thermographic procedure is performed in order to analyze temperature patterns on the body that may or may not indicate the presence of an abnormal process. Consequently, a normal thermogram does not rule out the presence of significant pathology. All thermography reports are meant to identify heat patterns that suggest potential risk markers only and do not in any way suggest diagnosis and/or treatment. Your thermogram report is meant to be used by your treating doctor as an adjunctive aid in the assessment of your health. The report is not to be used for self diagnosis and/or treatment. \_\_\_\_\_

I understand that infrared imaging of the breast is not intended as a replacement for or alternative to mammography, ultrasound, MRI or any other form of imaging. Thermography is not a stand-alone screening tool, meaning that it is not to be used by itself for screening. \_\_

I understand that infrared imaging of the breasts and mammography do not provide the same information on breast tissues; and therefore, provide different values on breast tissue assessment (thermography looking for physiological changes and mammography looking for anatomical changes). \_\_\_\_\_

I understand that the doctor and/or technician providing the infrared imaging, and the doctor interpreting the images, are not diagnosing and/or treating breast abnormalities. Follow up care relating to treatment must be done by properly trained and licensed health care specialists. \_\_\_\_\_

I understand that if, by any chance, a questionable thermal finding is discovered on my thermogram, I will comply with any and all follow-up or referral recommendations made on my report; such as following up with an ultrasound / mammogram / MRI / etc. or with my primary care doctor to ensure I receive proper care. \_\_\_\_\_

I understand that I will be disrobed from the waist up for breast exams and buttocks exposed for lower body exams. I will then be imaged with an infrared camera. I understand that this procedure does not use radiation, is not harmful to me, the equipment does not touch my body, and that its sole function is to produce an image of the heat coming off my body. \_\_\_\_\_

I understand that thermography reports do not in any way suggest diagnosis and/or treatment. No surgical procedure should be based on thermal imaging alone. Additional procedures, which depend on the nature of the condition and/or body region, are needed to achieve a final diagnosis. \_\_\_\_\_

I understand that thermography must not be confused with EBT, CT, or MRI full body imaging. These are structural imaging technologies that look for the physical presence of tumors and other structure changes inside the body. Thermography does not provide this type of imaging; and as such, cannot be used to screen for the spread of cancer (metastasis). \_\_\_\_\_

I understand that the results of my thermograms may be made available to my doctors and others as I so designate for further analysis in the overall evaluation of my health. I have also been given pre-imaging instructions to follow and I acknowledge that I have complied with the preparation protocol prior to the procedure. \_\_\_\_\_

I understand that the information I have reported on the intake forms, and the resultant report and/or images, will be sent via facsimile and/or electronic mail to personnel involved in the process, and/or my health care provider(s). As such, my private health information has the possibility of being seen by unauthorized personnel. Having understood this I give my full consent to having my private health information sent via facsimile and/or email. A new encryption software is soon to be added to all clinics to address this issue \_\_\_\_\_

Having understood the above, and having received satisfactory answers to any and all questions that I may have had concerning the purpose and outcome, risk factors and benefits of thermography, I hereby consent to both initial and all subsequent infrared imaging.

Patient's (Guardian's) Name: \_\_\_\_\_

Patient's (Guardian's) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_