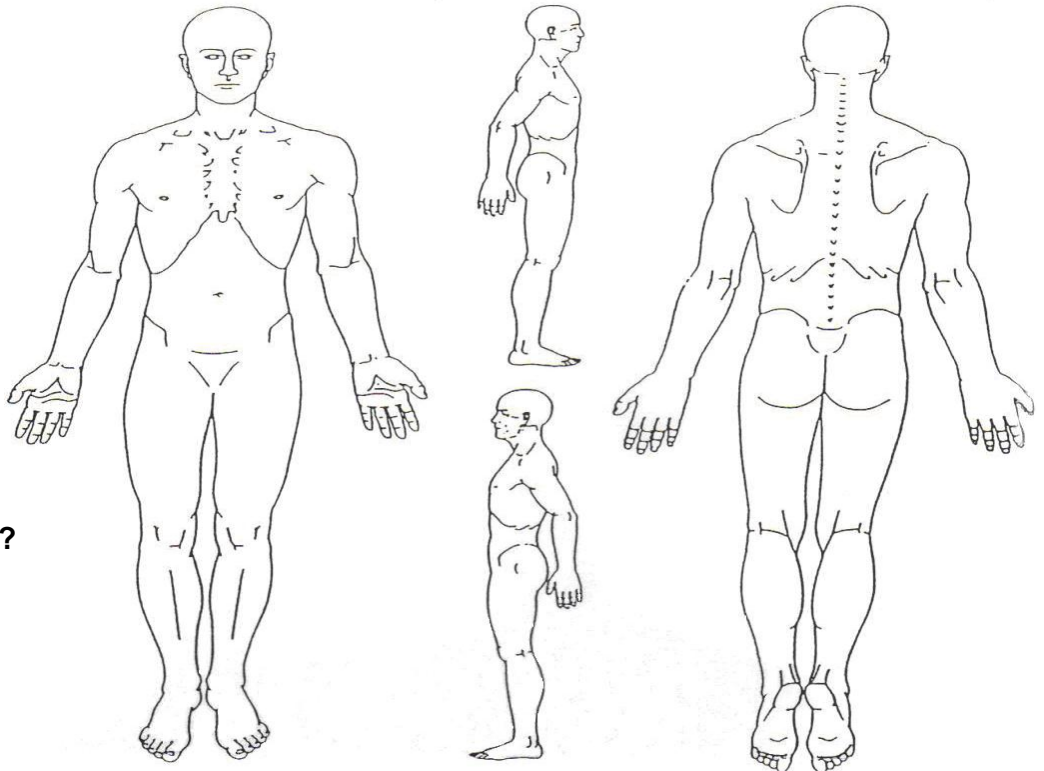


Health History Form

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

Please mark the area and type of pain on the drawing using the following code:

- N** – Numbness
- P** – Pain
- T** – Tingling
- A** – Ache
- S** – Soreness
- ST** – Stiffness



What are your chief complaints?

1. _____
2. _____
3. _____

Right
Left
Left
Left
Right

HABITS

- Smoking Packs/Day _____
- Drinking Alcohol _____
- Coffee Cups/Day _____

EXERCISE

- None
 - Moderate
 - Daily
- Type _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- | | | | |
|--|--------------------------------------|---|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> HIV Positive |

OPERATIONS AND PROCEDURES

DATE(S)		DATE(S)		DATE(S)	
_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach
_____	Other	_____	Other	_____	Other

Please Check One: Never – N, Previously – P1, Presently – P2

GENERAL SYMPTOMS

- N P1 P2
 Bronchitis
 Chills
 Convulsions
 Dizziness
 Fainting
 Fatigue
 Fever
 Headache
 Loss of sleep
 Loss of weight
 Nervousness
 Neuralgia
 Night sweats
 Numbness/pain in arms/legs/hands
 Wheezing
 Allergy to what: _____

GASTRO-

- N P1 P2 **INTESTINAL**
 Belching or gas
 Colon trouble
 Constipation
 Diarrhea
 Excessive hunger
 Gall bladder trouble
 Hemorrhoids (Piles)
 Jaundice
 Liver trouble
 Nausea
 Pain over stomach
 Poor appetite
 Poor digestion
 Vomiting
 Vomiting blood

EAR/NOSE/

- N P1 P2 **THROAT**
 Asthma
 Crossed Eyes
 Deafness
 Earache
 Ear discharge
 Ear noise
 Enlarged thyroid
 Frequent colds
 Hay fever
 Hoarseness
 Nasal obstruction
 Nose bleeds
 Pain in eyes
 Poor vision
 Sinusitis
 Sore throats
 Tonsillitis

RESPIRATORY

- N P1 P2
 Chest pain
 Chronic cough
 Difficulty breathing
 Spitting blood
 Spitting phlegm

GENITO-URINARY

- Bed wetting
 Blood in urine
 Frequent urination
 Inability to control urine
 Kidney infection
 Painful urination
 Prostate trouble

MUSCLES & JOINTS

- Backache
 Foot trouble
 Hernia
 Pain between shoulders
 Painful tailbone
 Stiff neck
 Spinal curvature
 Swollen joints
 Tremors
 Twitching
 Weakness

CARDIO-VASCULAR

- High blood pressure
 Low blood pressure
 Pain over heart
 Poor circulation
 Heart trouble
 Rapid heart
 Slow heart
 Stroke
 Swollen ankles
 Varicose veins

SKIN OR ALLERGIES

- Boils
 Bruise easily
 Dryness
 Eczema
 Hives or allergy
 Itching
 Sensitive skin
 Skin eruptions

FOR WOMEN ONLY

- Cramps or backaches
 Excessive flow
 Hot flashes
 Irregular cycle
 Miscarriage
 Painful periods
 Vaginal discharge
 Y N Pregnant at this time?

List any accidents or falls and dates: Car _____ Recreation Vehicle _____

Sports _____ School _____ Other _____

List any broken bones (fractures) or dislocations: _____

Were you ever on crutches? No Yes Why? _____

Have you ever had X-rays taken? No Yes When? _____

For what ailments were these X-rays taken? _____

Have you ever had any spinal taps or spinal injections? No Yes

Were you ever knocked unconscious? No Yes Have you ever had a lapse of memory? No Yes

Do you suffer from any condition other than that which has been listed previously? _____

Are you currently taking any medication - prescription or over-the-counter? No Yes

If yes, what medications: _____

I have completed this 3-page form to the best of my ability.

Signature: _____

Date: _____

Office Use Only	Tech: _____	Re-Exam: Y	Span: _____	Pt T: _____	Rm T: _____
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Holistique Medical Center Infrared Breast Imaging - Patient Intake Form

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 physical breast exam by a doctor: _____ NML Lump Thickening - R L

What follow up tests did your doctor recommend after this last exam? _____

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 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

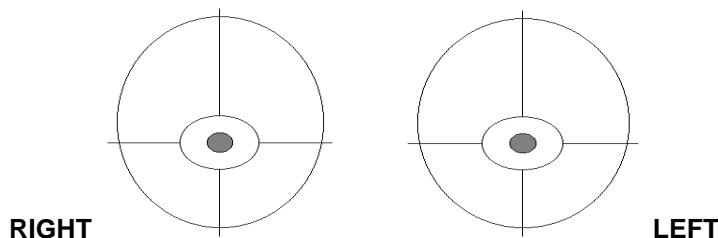
Thickening Skin changes (Color Texture Over the lump)

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,



High T: _____ Low T: _____ Initial Exam Re-Exam 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)