

Radiant Health Imaging Patient Intake Form

Name _____
DOB _____ Age _____
Street _____
Town/State/Zip _____
Occupation _____
E-mail _____
Phone (best #) _____

For office use only. Last scan date: _____	
Patient ID# _____	Next Appt. _____
Rpt Ref # _____	B1 B2 BA B+ WHC HB FB ROI
Referred by _____	
Location _____	Scans uploaded _____
Pymt _____	ck # _____ V MC DISC AMEX

May we leave a msg? Y N How would you like your report sent? email print

Reason for today's visit: _____

Symptoms: _____

CURRENT Tx: _____

CURRENT Rx: _____

For females, date of last clinical breast exam _____ and mammo/us _____

HEALTH HISTORY

Illnesses DX/Dates: _____

Surgeries/Dates: _____

Injuries/Dates: _____

Family History: _____

We will send a copy of your report to your **referring** Health Care Provider only, if requested.

Name/address: _____

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

Signed: _____ Date of Service: _____

Breast Thermography Confidential Questionnaire

□

Name: _____ DOB: _____ Date: _____

- | | | |
|---|-----|----|
| 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	<input type="checkbox"/>	<input type="checkbox"/>
Tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Change in breast size	<input type="checkbox"/>	<input type="checkbox"/>
Areas of skin thickening or dimpling	<input type="checkbox"/>	<input type="checkbox"/>
Secretions of the nipple	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

This authorization will expire upon written request.

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 physiological changes in the breasts requiring further diagnostic testing. A screening baseline cannot be acquired while pregnant or lactating.

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 before the test
- shave your underarms or use lotions, powders, antiperspirants, therapeutic essential oils or makeup on the breast/chest/axilla areas
- 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 the breast region; the inflammation may cause a false positive result.

Thermography is performed by a female certified clinical thermographer and is completely private. You will be behind a curtain/screen while tech frames and focuses images on laptop.

There are no risks and no side effects.

Average time for the appointment is 30 minutes.

Please bring your REFERRING 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/MC/Disc/AMEX for payment.

If you have any questions, pls call our office. 641-469-6081

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



INFORMED CONSENT FORM

Please read the following and sign below.

I understand:

- Radiant Health Imaging, Inc. and its staff of certified thermographers will use Digital Infrared Thermal Imaging (DITI) to take images of specified region(s) of my body as requested.
- The images may identify abnormal heat patterns indicating objectively the body's response to pain and dysfunction and may require further investigation.
- The images will be interpreted by the medical staff at Electronic Medical Interpretation (EMI) Inc. (thermology specialists). The Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment and NOT intended for self-evaluation or self-diagnosis.
- DITI is not a substitute for adequate medical care and I intend to remain under the care of my primary healthcare provider.
- The Report will not tell me whether I have any illness, disease or condition, but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.
- DITI is not a replacement for any anatomical imaging (mammogram/ultrasound/MRI) rather an adjunctive tool.
- I am responsible for my own decisions regarding my health, wellness and nutrition. Therefore I hold Radiant Health Imaging harmless as to the results and interpretations resulting from this process.
- Radiant Health Imaging, Inc will keep all information shared by me completely confidential unless I provide a release in writing or as required by law (HIPAA).

Acknowledgement

By signing below I certify that I have read and understand the statements above and consent to the examination.

Name (please print)

Date

Date of Birth

Client Signature

Name, if other than client, and relationship to client