



280 East Deuce of Clubs
Show Low, AZ 85901
928-537-4242 office
928-496-0282 fax

Javier Manrique NMD

Instructions when preparing for your thermogram

In order to get the most reliable results possible for your thermogram, please comply with the following guidelines:

3 months prior

- No breast surgery, breast biopsies, chemotherapy, or radiation

7 days prior:

- No natural or artificial tanning

3 days prior:

- Avoid physical stimulation, examination, or compression of breasts.
- No Ultrasound or X-ray Mammogram
- No fevers over 101° F (we want a baseline when you are not sick or fighting an infection)

24 hours prior:

- No sauna or steam room
- No hot or cold packs directly on the breast area
- With your doctors permission, avoid Niacin (vitamin B3), Nitroglycerine, Niacin patch or migraine medication 500mg or above

The day of your scheduled Thermogram:

- Do not apply any skin creams, lotions, deodorants, perfume, or powders especially not on your breasts or underarms
- Do not shave or wax underarms or breast area
- No jewelry
- No tobacco
- No caffeinated coffee, tea or soda
- No exercise
- No bathing or showering
- Must be no bruising, rash, or skin irritation in breast area
- If you are breastfeeding, empty your breast 30-60 minutes before appointment
- Hair should be worn up or pulled back off your shoulders
- Wear a blouse and pants or skirt to your study (no dresses)
- If you are in an extremely hot or cold climate prior to appointment, extra time may be needed to reach an equilibrium temperature before acclimating

Arrive 15 minutes early with your completed patient history forms and waiver.

- Read through **The imaging process step by step** on our website GoodLifeHealthCenter.com or in our office before the day of your appointment.

Please contact us to reschedule your appointment if you have compromised the above conditions to avoid. We want to insure the reliability of your study and would rather reschedule than redo your study

Good Life Health Health Center

Name _____
Last First Middle

Date of Birth _____ AGE _____

For all questions below, if **YES**, please provide details, otherwise indicate **NO** and move on to the next question.

1. Previous thermology? NO YES

Date _____ Site _____

2. Have you **ever** been diagnosed with **breast cancer**?

NO YES Date of biopsy _____

Side: RIGHT LEFT

Stage 0 1 2 3 4 Unknown

Type: Ductal Lobular Inflammatory

Paget's Phyllodes Don't Recall

Surgery None Lumpectomy Mastectomy

Treatment None Radiation Chemotherapy

Date of Last Treatment _____

Reconstruction: None DIEP Lat Dorsi flap

SGAP TRAM flap Autologous fat graft

Implant Other _____ Date _____

3. Have you had non-cancer breast surgery? NO

YES Side: RIGHT LEFT

Aspirations Biopsy Implants Lift

Reduction Other _____

Date(s) _____

4. Have you had any **abnormal** results from breast testing? NO YES Side: RIGHT LEFT

Physical Mammogram Ultrasound MRI

DATE(s) _____

5. Have you ever been diagnosed with any type of **non-cancer** breast disease? NO YES

Side: RIGHT LEFT Type: Fibro-Cystic

Mastitis Other _____ Date _____

6. Have you **ever** been diagnosed with **ovarian** cancer?

NO YES Date of diagnosis _____

Stage: 1 2 3 4 Unknown

Date of Last Treatment _____

7. Have you had surgery for the removal of **both** ovaries?

NO YES Date of Surgery _____

8. Have you **ever** had radiation **treatments** to your chest or back? NO Yes Date or Age _____

ID Code _____
(Office Use Only)

STUDY DATE _____
(Office Use Only)

Study Type Routine STAT

9. Have you gained **more** than **30** pounds **after** you completed menopause? NA NO YES

10. Have **any** of your **blood relatives** been diagnosed with breast **or** ovarian cancer? NO YES

Mother Daughter(s) Sister(s) Aunt(s)

Cousin(s) Grandmother(s) Niece(s)

Other _____ Were they diagnosed

at the age of **40 or younger**? NO YES

List Relationship and Age when Diagnosed

11. Age at **first** mammogram _____ Total # _____

Date of **last** mammogram _____

12. Age at **first** menstrual period _____

13. Have you had endometrial ablation? NO YES

Date (or age) _____

14. Date (or age) of your **last** menstrual period _____

15. Have you **ever** used hormone contraceptives?

NO YES Age started _____ How long _____

15a. Did you use these drugs 4 or more years **before** your first child? NA NO YES

16. Have you taken contraceptives or **prescribed** hormone replacement therapy (HRT) containing **estrogen** in the past **three (3)** months? NO YES

Medication Name _____

17. Have you taken **prescribed estrogen (HRT)** 4 or more years? NO YES

18. Age at **first** pregnancy _____ Age at **first** childbirth _____

19. Are you **now** pregnant? MAYBE NO YES

20. Are you currently breastfeeding? NO YES

Breast Favored RIGHT LEFT EQUAL

How Long? _____

21. Did you breast feed any of your children for more than 6 months? NA NO YES

Good Life Health Center

INFORMED CONSENT and RELEASE

Your signature below will acknowledge that you have been offered, read and understand Thermo-Scan Reference Laboratory, LLC. Privacy practices, Informed Consent, Participation in Scientific and/or Medical Studies and the Authorization and Report Release; that you consent to the thermology procedure and instruct us to release your thermology report to the physician(s) and others you have specified on this form. Your signature also indicates you have complied with the preparation protocols as instructed.

With this release you give permission for your thermology images to be included in various medical or scientific research projects with strict provisions that will protect the confidentiality of your personal information. NO YES

Signature: _____ Date _____

Name _____
Last First Middle

Address _____
Number Street Apt.

City State Zip

Phone _____ E-Mail _____

Primary Physician _____ NMD DO MD

Physician's Address _____
Number Street Suite

City State ZIP Phone

Other Physician _____ DO MD

Physician's Address _____
Number Street Suite

City State ZIP Phone

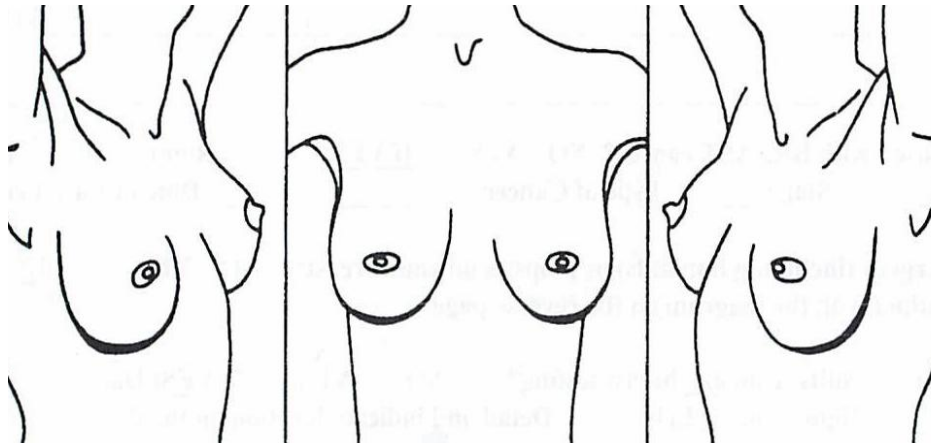
Please indicate the symptoms that you have experienced in the past 6 months and indicate the specific area(s) related to your symptom(s) on this drawing.

Right Breast

- Pain
- Tenderness
- Lumps
- Skin Thickening
- Discoloration
- Changes in Shape
- Changes in Size
- Rash

Right Nipple

- Discharge
- Discoloration



Left Breast

- Pain
- Tenderness
- Lumps
- Skin Thickening
- Discoloration
- Changes in Shape
- Changes in Size
- Rash

Left Nipple

- Discharge
- Discoloration

Technician Notes:

Technician Initials: _____

Thermo-Scan Reference Laboratory Use Only

Study # _____

R _____ L _____