Patient Preparation: Breast, Upper or Full Body Scan

Main consideration do not do anything that will stress joints, muscles, cause you to heat up or cause the skin surface to be blocked. **We cannot do a breast scan if you are pregnant or currently nursing, or if you have recently had any invasive procedure or surgery.

(Please contact office for more information)**

-Do not exercise, have therapies (massage, facials, PT, etc.), treatments or testing (MRI, CAT Scan, etc.) or electromyography on the same day Thermography is performed.

-You can shower as usual.

-Do not smoke for 2 hours before the test.

-Do not chew gum or drink hot beverages 2 hours before the test.

-Do not use under arm deodorants, lotions, *make-up, liniments or powder on your body or face on the day of test as they will block the skin surface from registering correct temperatures.

**For Breast Scans ONLY - you can wear make-up.

-Avoid sun exposure on day of test.

-Medicines - No changes necessary

Description of Test: Patient time for test: approx. 30-60 minutes. You are given time for your skin temperature to equalize with the room temperature. -Disrobing - You will be removing clothing down to underwear. **Men, please wear briefs rather than boxer shorts for Full Body scans. Remove all jewelry, Putting on a supplied gown, Pulling hair up and off face and away from ears & neck.Examining rooms can feel cool as your body adjusts to room temperature. Thermal Images are taken of the whole body, or just areas under investigation.

A Female Certified Thermographer will perform the test. You are welcome to bring a companion or partner to be present at the examination.

Patient Responsibility: *Patient will be responsible for providing report to his/her practitioner.

***Payment in full is expected at time of scan. Preferred payment is check or cash, but we do accept all credit cards.**

***Reminders will be emailed or texted, (if you are opted-in to receive texts), and is ultimately the patient's responsibility to schedule all future appointments.**

While participation in a DITI early detection program can increase your chance of detecting and monitoring breast disease, as with all other tests, it is still not a 100% guarantee of detection.

Dynamic Thermal Imaging

585-734-6083

info@nydti.com

www.nydti.com

Confidential Client Case History

Patient Information

Patient ID: ____________ ____________

Name Mr Mrs Ms Dr Date: ____________

First/MI/Last____________

Address____________

City/State/Zip____________

Sex: ☐ F ☐ M Age____ DOB ____________

Height: ____________ Weight: ____________

Occupation: ____________

Learned of us via:____________

Phone Numbers

Phone (H): ____________

Phone (W): ____________

Cell: ____________

E-mail: ____________

Name & Address of Health Care Provider you wish report sent to: ____________

____

____

Were you referred by this Provider? Yes___ No ___

(NOTE: ***In the absence of a complete address, reports will be mailed to the patient for submission to their provider.*****)**

Current Medications	Altern. Therapies	Surgeries/Dates	Location of scars/tattoo's
	Nutritional Supplements		
	Chiropractic / DO		
	Acupuncture / Massage		
	Reiki / PT / Exercise		
	Other		

Fractures/Injuries:

____

____

Smoking Hx:
Do you smoke? ___Yes ___Never ___ Not in last 12 months ___ Not in last 5 years Began age _____ For # Years_____

Family Health History (Any Cancer/Type; Heart Disease; Diabetes)

Maternal Side Key: M= Mother; S= Sister; B= Brother
MA/MU= Maternal Aunt/Uncle
MGM/MGF= Maternal Grandmother/Grandfather

____

____

____

____

Paternal Side Key: F= Father
PA/PU = Paternal Aunt/Uncle
PGM/PGF = Paternal Grandmother/Grandfather

____

____

____

____

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

Signed ____________ Date ____________

For Official Use Only. IM _____ C_____ DRP _____ A ____________
Scan Type:____________ Location: ____________ / ____________
Coding: ____________ Other:____________

Current Health Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name: ______________________________ Birthdate: ______________

Please make notations as related to the area(s) for which this study is being performed.

Please Show areas of :

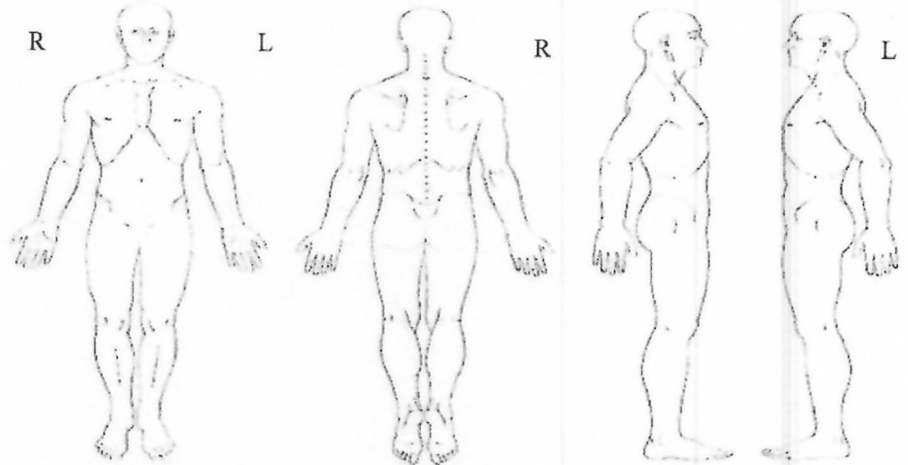
Main Pain *

Secondary Pain ○

Numbness ////////

Pins and needles ::::::::

Skin lesions / scaring/ piercing



Health History: Note "C" for current conditions you have or "P" for those in the past

□ Head Region:
___ Migraine Headaches
___ Sinus Problems
___ Cataracts
___ Glaucoma
___ TMJ - R / L
___ Ear Infection
___ Hearing Loss
___ Tinnitus
___ Other

□ Neck Region
___ Thyroid (Hypo/Hyper)
___ Carotid Arteries Narrow
___ Sore Throat (on scan date)
___ Other

□ Lungs
___ Asthma
___ Bronchitis/Pneumonia
___ COPD/Emphysema
___ Cold/Flu (on scan date)
___ Emphysema
___ Tuberculosis
___ Other

□ Vascular
___ Blood Clots
___ Heart Disease
___ High Blood Pressure
___ High Cholesterol
___ Pacemaker
___ Poor Circulation
___ Stroke
___ Vascular Disorder
___ Varicose Veins
___ Other

□ Digestive Disorders
___ Gastric Reflux
___ Indigestion
___ Irritable Bowel Syn
___ Diverticulitis
___ Polyps
___ Ulcers
___ Frequent Urination
___ Colonoscopy
___ Other

□ Skin
___ Acne
___ Rash
___ Other

□ Other Organs
___ Adrenal Stress
___ Kidney Disease
___ Liver Disease
___ Hepatitis
___ Other

□ Muscular/Skeletal
___ Arthritis
___ Carpel Tunnel R or L
___ Herniated Disk
___ Joint Degeneration
___ Nerve Damage
___ Osteoporosis/penia
___ Other

□ Female
___ Hot Flashes
___ Hysterectomy
___ Ovarian Fibroids
___ Uterine Fibroids
___ Vaginal Infection
___ Other

□ Males
___ Prostate Problem
___ Vasectomy
___ Other

□ Anemia
□ Allergies
□ Cancer/Tumors/Growths
□ Diabetes
□ Epilepsy
□ Fibromyalgia/CFS
□ Gout
□ Hernia
□ Multiple Sclerosis
□ Parkinson's Disease
□ Prosthesis
□ Shingles
□ Other ______________
____
____

□ Dental
Last Visit______________
____

Root Canals # _____
Extracted Teeth: _________
Partials ___Upper ___ Lower
Permanents ___ Y ___ N
Amalgams Removed? _____
Chew gum regularly? _____
Braces (age)? __________

Primary reason(s) for having a Thermography Scan / Clinical Concerns:

Patient Disclosure

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to bus used by individuals for self-evaluation or self-diagnosis.

I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings of the areas discussed in the Report.

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

Signature: ______________________________ **Date:** ______________________

Name: ______________________ Pt# __________ Birth date: ____________________

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Breast Thermography Confidential Questionnaire

		Yes	No
1.	Do you have any close relative who has had breast cancer?	☐	☐
2.	Have you ever been diagnosed with breast cancer?	☐	☐
3.	Have you ever been diagnosed with any other breast disease (fibrocystic)?..........	☐	☐
4.	Have you had any biopsies or surgeries to your breasts?	☐	☐
5.	Have you had any breast cosmetic surgery or implants? ________ Date	☐	☐
6.	Date of last mammogram ________________		
7.	Results of last mammogram ____________________		
8.	Have you had abnormal results from any breast testing in the past?	☐	☐
9.	Have you ever taken a contraceptive pill? Age:________ Duration: __________	☐	☐
10.	Have you suffered with cancer of the womb?	☐	☐
11.	Have you had Pharmaceutical or Bioidentical hormone replacement therapy? ..	☐	☐
12.	Do you have an annual physical examination by a doctor?	☐	☐
13.	Do you perform a monthly breast self exam?	☐	☐

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: _____ Vaginal/C-Sect._____

17. Did your periods start before the age of 12? ☐ Y ☐ N Or finish after the age of 50? ☐ Y ☐ N

18. Do you smoke? ☐ Yes ☐ Never ☐ Not in last 12 months ☐ Not in last 5 years

Began age ________ For # Years _______ Smoked # cig/cigars per day/wk __________

Have you recently had any of these breast symptoms:	Right Breast	Left Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

Diagnosed with Breast Cancer:

Key: UO = Upper Outer UI = Upper Inner LO = Lower Outer LI = Lower Inner

Cancer types: Metastatic _____ Local _____ Lymph node involvement _____

When diagnosed: Month _____ Year _____

Where (left breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Where (right breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Treatment: Surgery _____ Chemo _____ Radiation _____ Other _____ None _____

Diagnosed with other breast conditions: (please report other types of disease in the history)

Disease types: Fibrocystic _____ Cystic _____ Mastitis _____ Abscess _____ Other _____

Breast biopsies or surgery: (Please list dates and any known results)

Where (left breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

Where (right breast): UO _____ UI _____ LO _____ LI _____ Nipple _____

When: ____

Authorization to Use or Disclose Protected Health Information
Dynamic Thermal Imaging

Patient Name: ____

Address: ____

City: ____________________ State:_________ Zip Code: ______________

Date of Birth: ____________________ Date of Appt.: ______________

As required by the Privacy Regulations, ***Dynamic Thermal Imaging*** 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), and

Doctor(s): ____

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s):

____ Relationship ______________

Patient Health Information authorized to be disclosed: ***Thermal Images and related health history***

For the specific purpose of (describe in detail): ***Interpretation of said images***

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____/
This authorization will expire at the end of the above period.

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 of Patient or Patient's Authorized Representative *Date*

____ ______________
Authorized Signature of Facility *Date*

Pt# ______________

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Dynamic Thermal Imaging Informed Consent

-I understand that Digital Infrared Thermal Imaging (DITI) is used to identify thermal findings which may suggest abnormal physiology. It is a way of monitoring breast health over time.

-I understand that the ability to interpret the first breast study is limited since there are no previous images for comparison.

-I understand that the purpose of the two initial breast studies (usually obtained three months apart) is to establish the baseline pattern to which all future Thermography scans are compared against to monitor stability.

-I understand that Breast Thermography screening is an adjunctive test to mammography, ultrasound and MRI. Thermography is a specialized physiological test designed to detect angiogenesis, hyperthermia from nitric oxide, estrogen dominance, lymph abnormality and inflammatory processes including inflammatory breast disease, all of which cannot be detected with structural tests.

-I understand that this exam is an adjunctive procedure and all interpretive findings must be clinically correlated and that DITI is not a substitute for mammography nor a stand -alone test.

-I understand that Thermography will not show any cancers from a structural or pathological perspective.

-I understand that Thermography will show positive physiological findings in 83% of malignancy (specificity), leaving 17% of cancers that present as thermographically silent. This can be due to the type of pathology, or a long term cancer which the body has accommodated or encapsulated.

By my signature below I acknowledge that I understand the above criteria.

___________________________________ _______________

Patient's Name (Print Please) Birthdate

___________________________________ _______________

Patient's Signature Date

___________________________________ _______________

Authorized Signature of Dynamic Thermal Imaging Date

Pt# ______________