THERMOGRAPHY PREPARATION INSTRCUTIONS

Lotus Path Wellness Center 3642 Madaca Lane Tampa, FL 33618 813.964.0847

Thank you for choosing Lotus Path Wellness Center as your source for thermal imaging. We look forward to meeting you and assisting you with this safe and effective procedure.

1. Please ARRIVE at the office 15 minutes before your appointment to allow for the cool down process.

2. DO NOT bring small children with you who cannot be left unattended.

3. Please be prepared to pay for your examination at the time of your visit. Check, cash, Visa, MasterCard, and Discover are accepted. Make checks Payable to: **Lotus Path Wellness Center**

IMPORTANT PROTOCOLS

If you have a fever, please call to reschedule.

24 hours prior to exam: avoid chiropractic care, sun tanning or tanning beds, physical therapy, massage therapy, acupuncture, saunas, steam baths, hot tubs, magnets, heating pads, hot water bottles, analgesic creams or balms, and do not shave under arms for breast scans, do not shave face or body for health screen or full body scans.

12 hours prior to exam: do not stimulate the nipple in any way.

4 hours prior to exam: No coffee, tea, soda or other beverages or medications containing caffeine. No alcoholic beverages. No gum chewing. Do not bathe or shower in HOT water. Do not perform any **rigorous** exercise program. Do not touch or rub yourself anywhere near your breasts.

The day of the exam: do not use creams, lotions, ointments, deodorants, antiperspirants, powders or any other skin product on or around the area of your scan . Do not smoke cigarettes or use any product which contains nicotine at least 2 hours prior to exam. Do not use any medication or natural supplement that causes flushing (i.e. Niacin).

Please do not turn your a/c vents in car directly on you while driving to the exam. This can make your body too cold.

Inform us if you have had a breast biopsy within 1 month; breast surgery, chemotherapy or radiation treatment within the last 2 months. If breast feeding-please wait until 3 months after no longer breast feeding to schedule exam.

Remove all piercings and jewelry prior to exam. If you have long hair (touches your shoulders) bring a hairband to hold it off of the neck.

In preparation for your session, do not discontinue any medication or therapy without your doctor's permission.

(REV 2/14)

Lotus Path Wellness Center

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, Lotus Path Wellness Center 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 Lotus Path Wellness Center 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:

Physicians Insight, LLC

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

For the specific purpose of: **Interpretation of said images**

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 affect 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*

_____

Confidential Questionnaire

Breast

Name_____Birth Date_____Today's Date_____
Address_____City_____State_____Zip_____
Phone Number Home_____Cellular_____Work_____
E-Mail Address_____
Referring Physician_____

Is there a specific reason or concern for this exam?

	Yes	No
1. Have you recently had any of these breast symptoms?	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin thickening or dimpling	○	○
Excretions of the nipple	○	○

2. Are any of the above symptoms cycle related? ○ ○

3. Are you still having your periods? ○ ○
   If yes, date of last period_____

4. Have you had a surgical hysterectomy? ○ ○
   If yes, date_____ ○ Complete ○ Partial
   Reason for hysterectomy?
   ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? ○ ○
   If yes, note age and survival ○ Mother ○ Grandmother ○ Siste ○ Daughter
   Age_____ Survival: Yes_____No_____

6. Have you ever been diagnosed with breast cancer? ○ ○
   If yes, date_____
   Cancer type ○ Local ○ Metastatic ○ Lymph node involvement
   Left breast ○ Inner ○ Outer ○ Nipple
   Right breast ○ Inner ○ Outer ○ Nipple
   Treatment ○ Surgery ○ Chemo ○ Radiation ○ None

7. Have you ever been diagnosed with any other breast disease? ○ ○
   If yes, ○ Cysts/fibrocystic ○ Mastitis/inflammatory breast disease

8. Have you had any cosmetic breast surgery or implants? ○ ○
   If yes, date_____ ○ Silicone ○ Saline
   Experience ○ Problems ○ No problems

	Y	N
9. Have you ever had any biopsies or any other surgeries to your breasts?	○	○
If yes, date_____		
Left breast ○ Inner ○ Outer ○ Nipple		
Right breast ○ Inner ○ Outer ○ Nipple		
Results ○ Negative ○ Positive ○ Calcifications		
10. Have you ever taken contraceptive pills for more than one year?	○	○
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years		
11. Have you had pharmaceutical hormone replacement therapy (HRT)?	○	○
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years		
12. Do you have an annual physical examination by a doctor?	○	○
13. Do you perform a monthly breast self exam?	○	○
14. Have you ever smoked?	○	○
15. Have you ever been diagnosed with diabetes?	○	○
16. Date of your last mammogram_____ Were you re-called?_____	○	○

17. How many mammograms have you had in total?_____
18. Your age at your first mammogram?_____
19. Number of full term pregnancies?_____
20. Your age at birth of your first child?_____
21. Age when you started your period?_____

Do you have any special concerns or are there any details related to the information above?

Procedure: *You will be imaged with a state of the art infrared imaging camera in comfortable and controlled surroundings. Your thermal imaging baseline reports will provide information about current and future conditions only and does not diagnose breast disease. Thermal imaging should be correlated with other medical investigative methods to better direct definitive testing for diagnosis and treatment. It does not replace any other breast examination.*

Patient Disclosure: *I understand that the report generated from my images is intended for use by a trained health care provider to assist in evaluation and treatment. I further understand that the report is not intended to be used by myself for self-evaluation or self-diagnosis. I understand that the report will not tell me whether, I have any illness, diseases, or other conditions, but will be an analysis of the images with respect only to the thermographic findings discussed in the report.*

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

Patient Signature_____Today's Date_____

Revised 6-11-12

Confidential Questionnaire

Female *Full Body*

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cellular)_____(work)_____

E-Mail Address_____

Referring Physician_____

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.

Head & Neck

	Yes	No
1. Do you suffer with headaches? If yes, ○ once a month or less ○ more than once a month	○	○
2. Do you have allergies?	○	○
3. Do you have TMJ or does your jaw click?	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder?	○	○
6. Do you have neck pain?	○	○
7. Do you have upper back pain?	○	○
8. Do you have a history of carotid artery disease?	○	○
9. Do you have a family history of stroke?	○	○
10. Do you currently suffer with sinus problems?	○	○

Do you have any special concerns or are there any details related to the information above?

Breast

Is there a specific reason or concern for your exam?

	Yes	No
1. Have you recently had any of these breast symptoms?	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin thickening or dimpling	○	○
Excretions of the nipple	○	○

2. Are any of the above symptoms cycle related? ○ Yes ○ No

3. Are you still having periods? ○ Yes ○ No
   If yes, date of last period_____

4. Have you had a surgical hysterectomy? ○ Yes ○ No
   If yes, date_____ ○ Complete ○ Partial
   Reason for hysterectomy?
   ○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other

5. Has anyone in your family ever been treated for breast cancer? ○ Yes ○ No
   If yes, ○ Mother ○ Grandmother ○ Sister ○ Daughter
   If yes, Age disgnosed_____ survived: Yes_____No_____

6. Have you ever been diagnosed with breast cancer? ○ Yes ○ No
   If yes, date_____

Cancer type	○ Local	○ Metastatic	○ Lymph node involvement	
Left breast	○ Inner	○ Outer	○ Nipple	
Right breast	○ Inner	○ Outer	○ Nipple	
Treatment	○ Surgery	○ Chemo	○ Radiation	○ None

7. Have you ever been diagnosed with any other breast disease? ○ Yes ○ No
   If yes, ○ Cysts/fibrocystic ○ Mastitis/inflammatory breast disease
   ○ Fibro Adenoma

8. Have you had any cosmetic breast surgery or implants? ○ ○

If yes, date_____ ○ Silicone ○ Saline

Experience ○ Problems ○ No problems

9. Have you ever had any biopsies or any other surgeries to your breasts? ○ ○

If yes, date_____

Left breast ○ Inner ○ Outer ○ Nipple

Right breast ○ Inner ○ Outer ○ Nipple

Results ○ Negative ○ Positive ○ Calcifications

10. Have you ever taken contraceptive pills for more than one year? ○ ○

If yes, ○ Currently ○ Took for less than 5 years ○ Took for more than 5 years

11. Have you had pharmaceutical hormone replacement therapy (HRT)? ○ ○

If yes, ○ Currently ○ Taken less than 5 years ○ Taken more than 5 years

12. Do you have an annual physical examination by a doctor? ○ ○

13. Do you perform a monthly breast self exam? ○ ○

14. Have you ever smoked? ○ ○

15. Have you ever been diagnosed with diabetes? ○ ○

16. Date of your last mammogram_____ Were you re-called?_____ ○ ○

17. How many mammograms have you had in total?_____
18. Your age at your first mammogram?_____
19. How many full term pregnancies?_____
20. Your age at birth of your first child?_____
21. Age when you started your period?_____

Do you have any special concerns or are there any details related to the information above?

Chest, Heart & Lungs

	Yes	No
1. Have you ever been diagnosed with:		
Heart disease?	○	○
Lung disease?	○	○
Upper spine disorders?	○	○
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
4. Have you ever had surgery to:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
5. Do you have asthma or shortness of breath?	○	○
6. Do you currently smoke?	○	○
7. Have you smoked in the last 5 years?	○	○

Do you have any special concerns or are there any details related to the information above?

Abdomen & Lower Back

	Yes	No
1. Do you suffer with acid reflux?	○	○
2. Do you have pain in the:		
Stomach?	○	○
Below the right breast?	○	○
Below the left breast?	○	○
Abdomen?	○	○
Lower back?	○	○

	Yes	No
3. Have you had surgery or disease in the:		
Stomach?	○	○
Spleen? Left upper quadrant	○	○
Liver? Right upper quadrant	○	○
Kidneys?	○	○
Intestines?	○	○
Abdomen?	○	○
Lower back?	○	○

Do you have any special concerns or are there any details related to the information above?

Legs and Feet

(Check only if "yes")

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Leg?	○	○	Leg?	○	○
Sciatica?	○	○	Sciatica?	○	○
Buttocks/Hip?	○	○	Buttocks/Hip?	○	○
Knees?	○	○	Knees?	○	○
Ankles?	○	○	Ankles?	○	○
Feet?	○	○	Feet?	○	○

Do you have any special concerns or are there any details related to the information above?

Arms & Hands

(Check only if "yes")

1. Do you suffer with pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Shoulder?	○	○	Shoulder?	○	○
Elbow?	○	○	Elbow?	○	○
Arm?	○	○	Arm?	○	○
Hands?	○	○	Hands?	○	○

	Yes	No
3. Have you ever been diagnosed with diabetes?	○	○

Do you have any special concerns or are there any details related to the information above?

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

Patient Signature_____Today's Date_____

Confidential Questionnaire

Women's Health Screening with Abdomen

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Phone Number (home)_____(cellular)_____(work)_____

E-Mail Address_____ Referring Physician_____

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.

Head & Neck

	Yes	No
1. Do you suffer with headaches?	○	○
If yes, ○ once a month or less ○ **more** than once a month		
2. Do you have known allergies? Food ____ Environmental___	○	○
3. Do you have TMJ or does your jaw click?	○	○
4. Do you currently have a cold?	○	○
5. Are you being treated for a thyroid disorder? Type_____	○	○
6. Do you have neck pain?	○	○
7. Do you have upper back pain?	○	○
8. Do you have a known history of carotid artery disease?	○	○
9. Do you have a family history of stroke?	○	○
10. Do you currently suffer with sinus problems?	○	○

Do you have any special concerns or are there any details related to the information above?

Breast

Is there a specific reason or concern for this breast exam?

	Yes	No
1. Have you recently had any of these breast symptoms?	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○

Revised 7-1-13

Areas of skin thickening or dimpling	○	○
Excretions of the nipple	○	○

	Yes	No
2. Are any of the above symptoms cycle related?	○	○
3. Are you still having periods?	○	○

If yes, date of last period_____

4. Have you had a surgical hysterectomy? ○ ○

If yes, date_____ ○ Complete ○ Partial

Reason for hysterectomy:

○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other _____

5. Has anyone in your family ever been treated for breast cancer? ○ ○

If yes, ○ Mother ○ Grandmother ○ Sister ○ Daughter

Age diagnosed _____ Result of Treatment_____

6. Have you ever been diagnosed with breast cancer? ○ ○

If yes, date_____

Cancer type	○ Local	○ Metastatic	○ Lymph node involvement	
Left breast	○ Inner	○ Outer	○ Nipple	
Right breast	○ Inner	○ Outer	○ Nipple	
Treatment	○ Surgery	○ Chemo	○ Radiation	○ None

7. Have you ever been diagnosed with any other breast disease? ○ ○

If yes, ○ Cysts/fibrocystic ○ Fibro Adenoma ○ Mastitis/inflammatory breast disease

8. Have you had any cosmetic breast surgery or implants? ○ ○

If yes, date_____ ○ Silicone ○ Saline

Experience ○ Problems ○ No problems

9. Have you ever had any biopsies or any other surgeries to your breasts? ○ ○

If yes, date_____

Left breast	○ Inner	○ Outer	○ Nipple
Right breast	○ Inner	○ Outer	○ Nipple
Results	○ Negative	○ Positive	○ Calcifications

10. Have you ever taken contraceptive pills for more than one year? ○ ○

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

11. Have you had pharmaceutical hormone replacement therapy (HRT)? ○ ○

If yes, ○ Currently ○ Less than 5 years ○ More than 5 years

12. Do you have an annual physical examination by a doctor? ○ ○

13. Do you perform a monthly breast self exam? ○ ○

14. Have you ever smoked? ○ ○

15. Have you ever been diagnosed with diabetes? ○ ○

16. Total Mammograms _____

17. Date of your last mammogram_____ Were you re-called? ○ ○

18. Your age at your first mammogram?_____

19. Number of full term pregnancies?_____

20. Your age at birth of your first child?_____

21. Age when you started your period?_____

Chest, Heart & Lungs

1. Have you been diagnosed with:	**Yes**	**No**
Heart disease?	○	○
Lung disease?	○	○
Upper spine disorders?	○	○
2. Do you suffer with upper back pain?	○	○
3. Do you suffer with chest pain?	○	○
4. Have you ever had surgery to your:		
Heart?	○	○
Lungs?	○	○
Mid to upper back?	○	○
5. Do you have asthma or shortness of breath?	○	○
6. Do you currently smoke?	○	○
7. Have you smoked in the past 5 years?	○	○

Abdomen & Lower Back

	Yes	**No**		**Yes**	**No**
1. Do you suffer with acid reflux?	○	○	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	○	○
Stomach?	○	○	Spleen(Upper Left) ?	○	○
Below R Breast?	○	○	Liver(Upper Right) ?	○	○
Below L Breast?	○	○	Kidneys ?	○	○
Abdomen?	○	○	Intestines ?	○	○
Lower Back?	○	○	Abdomen ?	○	○
Pelvic Region?	○	○	Lower Back?	○	○
			Pelvic Region?	○	○

Have you consumed alcohol in the past 24 hours? ○ ○

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Patient Signature_____ Today's Date_____