De Novo Scan
Clinical Thermography

Patient Pre-Screen Information

Screening with Digital Infrared Thermal Imaging

Purpose of test:

Early detection of abnormal changes in the breasts, lymphatic system and other areas of the body that may require or may not require further diagnostic testing (depending upon the findings via medical interpretation).

Patient preparation:

- You must wait at least three months after major breast surgery, completion of chemotherapy, or radiation before a thermal exam.
- You must wait at least one month after a biopsy or minor surgery
- Avoid tanning or sunburn for at least one week before the exam
- Do not eat one hour prior to your exam
- Do not eat or drink caffeinated products two hours prior to your exam
- Do not smoke or use any products containing nicotine two hours prior to your exam
- Do not exercise at least 12 hours prior to your exam
- Do not use lotions, powders, or deodorants the day of your exam
- Avoid taking any medications or supplements on the day of your exam if possible
- No alcohol for at least two days prior to your scan. Too much alcohol will affect hormone levels which will show up in your scan.
- Please wear loose fitted clothing
- For Half Body or Full Body Scans, hair will need to be pulled up off the neck, face/forehead (we have disposable hair supplies for your convenience)
- Please inform your Thermography Technician about any recent skin lesions or bruising, rosacea or any other skin disorders as it may cause false positives on reports.
- Please note that the camera will not be able to see through thick hair such as thick chest hair, thick body hair, thick shoulder/back hair. Please shave closely at least 3 days prior to your scan. (This seems apply more for men than women).

Procedure:

- To receive accurate results, the equilibrating time is 15 minutes and temperature is between 68-72 degrees.
- You will be asked to disrobe according to the type of scan chosen; the images, again depending on the type of study being done, will take approximately 20 – 45 minutes.

Patient Forms:

- To ensure the appropriate allotted time is allowed for your appointment, please print and complete the following patient forms and bring with you to your appointment.

De Novo Scan
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SCOTTSDALE
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PATIENT CONSENT FORM

NAME:		**DOB:**	
ADDRESS:		**CITY/ST/ZIP:**	
CELL PHONE:		**HOME PHONE:**	
EMAIL:		**HOW DID YOU FIND US?:**	
PHYSICIAN'S INFO:			

SELECT SCAN: ____ **Breast Scan** ____ **Half Body Scan** ____ **Full Body Scan** ____ **Spot View(s)**

According to a study in the American Journal of Radiology Jan. '03, Thermography is 97% sensitive in detecting breast cancer. In comparison, mammography can only detect 35% of breast cancers (New England Journal of Medicine July '04, Lancet May '05, Journal of the American Medical Association September '04).

_____I understand that the report generated from my images is intended for use by a trained healthcare provider to assist in evaluation, diagnosis and treatment. I understand the report is not intended for use by individuals for self-evaluation, diagnosis or treatment.

_____It is further understood that my thermal images are a unique personal fingerprint and that abnormal patterns can only be determined to be abnormal both by use of comparison of left and right sides of my body and also by examining changes over time. To establish a baseline, it is recommended that a repeat exam is done within three to six months to make an interval comparison. New examinations at one year intervals will be the norm and will reveal any interval abnormalities. The initial exams will be kept on file for immediate comparison.

_____I understand the report will not tell me whether I have an illness, disease, cancer 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. No diagnosis of malignant disease can be made without a biopsy of the mass or lump regardless of the type of scan.

_____I hereby authorize De Novo Scan and any of its employees to disclose my patient health information to Physician's Insight, the group of physicians interpreting my thermal images. I agree that if the initial exams are highly suspicious for a potential serious problem to accept advice for a referral to traditional imaging methods such as ultrasound (also non-invasive with zero radiation), mammography, breast MRIs or PET scans. A structural evaluation by one of these modalities is needed.

_____I understand that I have the right to: inspect a copy of patient health information being used or disclosed under federal law; receive a copy of this authorization; 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 health plan or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____I understand that my report will be sent to me via electronic mail (email). If by chance an email address is not available, my report will then be sent to me via US postal service. I also acknowledge that there is a fee of $10.00 should I need an additional printed copy of my report.

_____I understand that a Superbill will be provided to me upon request and that my insurance may not cover my procedure.

By signing below, I acknowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information to the reading doctor and the receipt of information from the reading doctor in the pursuit of comprehensive evaluation and treatment relating to the services provided by De Novo Scan and Physicians Insight.

Signature: _____ **Date:**_____

Print Name: _____

Confidential Questionnaire

Women's Health Screening with Abdomen

Name_____ Birth Date_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

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

Email_____ 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?	___	___
11. Do you have history of dental problems?	___	___
Root canals ____ Gum disease ____ Implants ____		
Non-replaced extractions ____ Dentures ____		
12. Have you had dental cleaning in the past 7 days?	___	___

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

Breasts

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

	Yes	No
1. Have you recently had any of these breast symptoms? (mark only if "yes")	___	___

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

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

3. Are you still having your periods? If yes, start 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 ○ Sister ○ Daughter

   Age diagnosed _____ Result of Treatment_____

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

   If yes, date: Month _____ Year _____

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

	Yes	No
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 last mammogram _____ Were you re-called?	___	___

18. Your age at your first mammogram?_____
19. Number of full term pregnancies?_____

20. Have you had breast ultrasound?	___	___
If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___		
21. Have you had breast MRI?	___	___
If yes…Date:____/____ Left ___ Right___ Results: Negative___ Positive ___		

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 or other digestive problems?	Yes___	No___	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	Yes___	No___
Stomach?	Yes___	No___	Spleen(Upper Left) ?	Yes___	No___
Below R Breast?	Yes___	No___	Liver(Upper Right) ?	Yes___	No___
Below L Breast?	Yes___	No___	Kidneys ?	Yes___	No___
Abdomen?	Yes___	No___	Intestines ?	Yes___	No___
Lower Back?	Yes___	No___	Abdomen ?	Yes___	No___
Pelvic Region?	Yes___	No___	Lower Back?	Yes___	No___
			Pelvic Region?	Yes___	No___

Have you consumed alcohol in the past 24 hours? Yes___ No___

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_____