Patient Pre-Screen Information

Screening with Digital Infrared Thermal Imaging

(Thermography)

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.

Test Results:

Reports are generally received within **5 to 7 BUSINESS** days after your initial visit.

Patient Forms:

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

De Novo Scan
Clinical Thermography

_____ **SCOTTSDALE**
8075 E. Morgan Tr., Suite 2 | Scottsdale, AZ 85258
Ph: 480.284.2222

_____ **CHANDLER**
1256 W. Chandler Blvd., Suite 22 | Chandler, AZ 85224
Ph: 480.822.9932

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 Dr. Gregory Melvin, DC, BCCT, the thermal reading doctor at Total Thermal Imaging in La Mesa, CA. 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: revoke this authorization by sending a written notice to this office and that revoking will not affect previous reliance on the uses or the disclosure pursuant to this authorization; inspect a copy of patient health information being used or disclosed under federal law; refuse to sign this authorization; 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 Total Thermal Imaging (Dr. Gregory Melvin, DC, BCCT).

Signature: _____ **Date:**_____

Print Name: _____

Gregory Melvin DC, BCCT (Reading Doctor)

8341 La Mesa Blvd., La Mesa, CA 91941 Phone: 619.303.5884

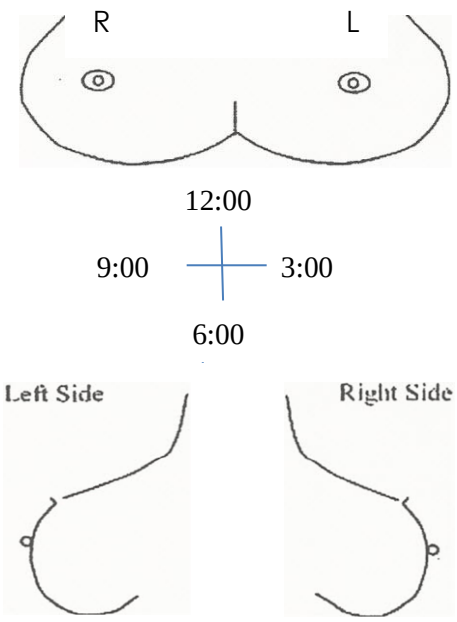
Room Temp:_____
Office use only

Name:_____ **DOB:**_____

Have you had a thermal scan before? Y____ N _____ When was your last thermal: ____/____/_____

Circle Yes/No and mark the "clock positions" of positive findings on the breasts illustration provided below.

1. Do you have any close relative that has breast cancer?	Yes	No	1a. If yes, relationship:_____
2. Have you ever been diagnosed with breast cancer?	Yes	No	2a. If yes, type: metastatic/lymph node When? Where? Right: Left:
3. Have you ever been diagnosed with any other breast disease?	Yes	No	3a. If yes, note it here:
4. Have you had any biopsies of the breast and your findings?	Yes	No	4a. If yes, findings: fibrocystic/calcium nodule When? Where? Right: Left:
5. Have you had breast cosmetic surgery or implants?	Yes	No	
6. Have you had a mammogram in the last 12 months?	Yes	No	
7. Have you had a mammogram in the last 5 years?	Yes	No	
8. How many mammograms have you had in total? _____			
9. At what age was your first mammogram? _____			
10. Have you ever taken a contraceptive for more than a year?	Yes	No	
11. Have you suffered uterine and/or ovarian cancer?	Yes	No	
12. Have you had pharmaceutical hormone replacement therapy?	Yes	No	
13. Do you have an annual physical examination by a doctor?	Yes	No	
14. Do you perform a monthly breast self-examination?	Yes	No	
15. Are you currently breast feeding?	Yes	No	
16. How many births have you had?_____			
17. What was your age when your first child was born? _____			
18. Did your menstrual periods start before age 12?	Yes	No	
19. Did your menstrual periods stop after the age of 50?	Yes	No	
20. Do you smoke? ___yes ___no ____how long? ___ packs/day			



Have you had any of the following breast symptoms in the last 6 months?

(Circle):	Yes	No	Left	Right	Both
• Pain	Y	N	L	R	B
• Lump(s)	Y	N	L	R	B
• Change in breast size?	Y	N	L	R	B
• Area of skin thickening or dimpling?	Y	N	L	R	B
• Secretion of the nipple(s)?	Y	N	L	R	B

Current health problems?	
Current medications?	
Previous Illness(es)?	
Previous Surgeries?	

Patient Signature:_____ **Date:**_____

Head/Neck/Chest

Do you suffer with:

	Y	N
Headaches	○	○
Allergies	○	○
TMJ or jaw clicking	○	○
Cold symptoms	○	○
Thyroid Disorder	○	○
Neck pain	○	○
Upper back pain	○	○
Chest pain	○	○
Carotid artery disease	○	○
Lung disease	○	○
Family history of stroke	○	○
Sinus problems	○	○

Surgeries related to heart/lungs/spine:

_____

_____

Abdomen

Do you suffer with:

_____Acid reflux

_____Stomach pain

Surgeries and/or disease of the following:

Stomach _____

Spleen _____

Liver _____

Diabetes _____

Kidneys _____

Intestines _____

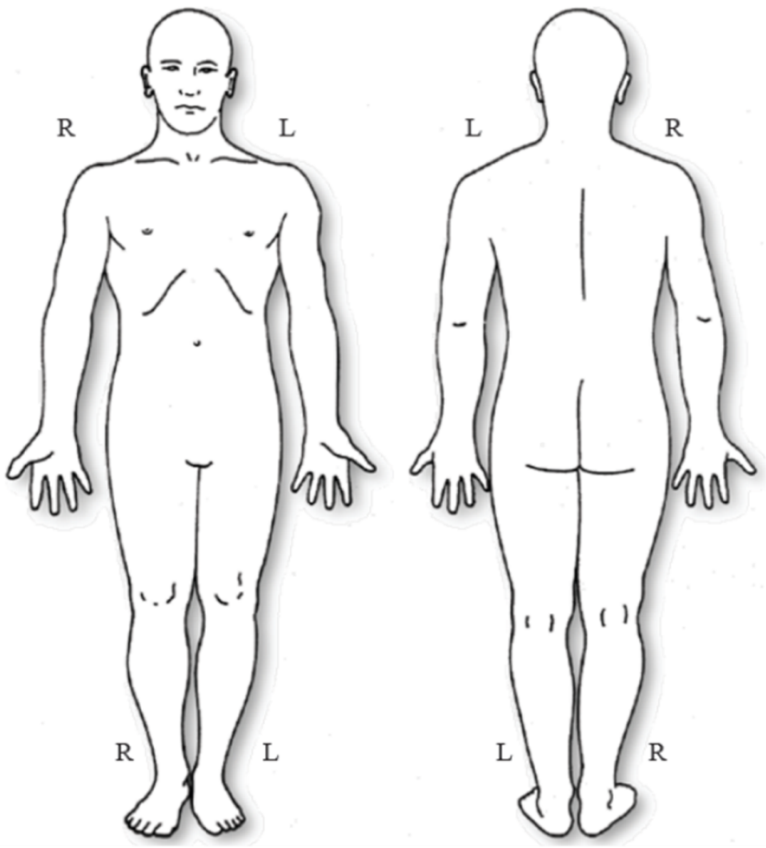
Arms/Hands/Legs/Feet

Do you suffer pain in or have had surgery on:

	Left	Right		Left	Right
Shoulder	L	R	Thigh	L	R
Elbow	L	R	Knee	L	R
Arm	L	R	Leg	L	R
Hands	L	R	Ankle	L	R
Hip	L	R	Foot	L	R

MARKINGS (please use the following letters when marking areas of the body):

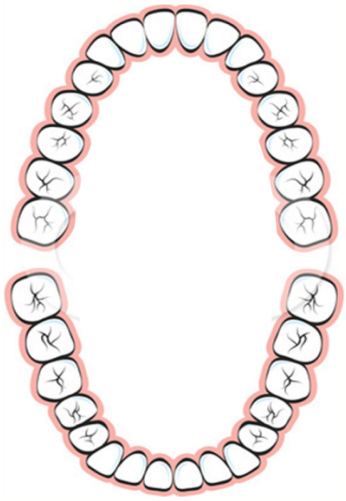
X = Pain and indicate level of pain by 1—10 (10 being severe)
N = Numbness | S = Scars | M = Moles | F = Fractures



Teeth/Gums

Please use the following letters when marking areas of the mouth:

RC = Root canal
C = Crown
S = Surgery
MF = Mercury Fillings
O = Other _____
_____



Accidents/Other

Please use this space to provide additional information (and dates) of injuries from past accidents:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Are you:** ____ **Left Handed or** ___**Right Handed?**