



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.

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 patient forms and bring with you to your appointment.



____ **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

____ **CENTRAL PHOENIX**
6102 N. 16th St., Suite 17 | Phoenix, AZ 85016
Ph: 602.892.8599

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

Men's Health Screening 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.

Yes No

Head & Neck

- | | | |
|---|-------|-------|
| 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?

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? _____

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

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_____