SPECTRUM THERMOGRAPHY

Patient Information Sheet.

Name …… D.O.B. ……..…….

Address ……City……Zip……

Phone…… Email ……..……..

Cell Phone…….. Text ok? Yes…. No……

Previous Illnesses.

Previous Surgery.

Current Health Problems

Medication. …….

Other Treatment. …….

Current Doctor. …….

Do you want your scans results sent to your health provider? Yes…. No….

If yes, provide a current email address or phone#……..

Have you had your Covid vaccination? …… Date……

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

Signed …….. Date ……..

Scan fees are nonrefundable once report and images have been received.

Women's Health Check

- ☐ Any close relative ever had breast cancer? Who? _____
- ☐ Ever been diagnosed with breast cancer?
- ☐ Ever been diagnosed with any other breast disease? _____
- ☐ Ever had any biopsies or surgeries to breasts?
- ☐ Ever had any breast cosmetic surgery or implants?
- ☐ Have dense breast tissue?
- ☐ Had a mammogram in the past 12 months?
- ☐ Had more than 30 mammograms in their lifetime?
- ☐ Had a mammogram in the past 5 years?
- ☐ Any abnormal results from any breast testing?
- ☐ Ever taken an oral contraceptive for more than 4 years?
- ☐ Ever been diagnosed with ovarian, uterine, or cervical cancer?
- ☐ Ever had hormone replacement therapy?
- ☐ Have an annual physical examination by a doctor?
- ☐ Perform a monthly breast self exam?
- ☐ Periods start before the age of 12?
- ☐ Periods end after the age of 50?
- ☐ Ever had any children? How many?_____ Your age at first birth?_____
- ☐ Do you smoke? □ Yes □ Never □ Not in last 12 months □ Not in last 5 years
- ☐ Ever smoked for more than 5 years?
- ☐ Is/was menstrual cycle irregular?
- ☐ Experience cramping during menstrual cycle?
- ☐ Observe heavy bleeding during menstrual cycle?
- ☐ Experience breast pain or tenderness
- ☐ Have any breast lumps?
- ☐ Ever have low libido?
- ☐ Ever have hot flashes?
- ☐ Have you had a hysterectomy? □ Partial □ Total
- ☐ Ever been diagnosed with endometriosis?
- ☐ Ever diagnosed with PCOS (poly cystic ovarian syndrome)?
- ☐ Ever been treated for infertility?
- ☐ Ever have any swelling in the neck or trouble swallowing?
- ☐ Ever been diagnosed with any thyroid disorder?
- ☐ Ever regularly experience fatigue?
- ☐ Ever experienced recent hair loss

Has the patient recently had any of these breast symptoms:

- ☐ Pain?
- ☐ Tenderness?
- ☐ Lumps?
- ☐ Change in breast size?
- ☐ Areas of skin thickening or dimpling?
- ☐ Secretions of the nipple?

Authorization to Use or Disclose Protected Health information

Spectrum Thermography LLC

Patient Name_____

Address_____City_____

State/Zip:_____ Date of Birth_____

As required by the Privacy Regulations, Spectrum Thermography LLC may not use or disclose your protected health information except as provided in our Notice of Privacy 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

Patient Health Information authorized to be disclosed: Thermal Images and related health history
For the specific purpose of (described in detail) Interpretation of said images

_____

I request my report and images to be sent to me:

___Via email on a PDF Report (no charge) email address:_____

___Via PDF on a writable disc by US Mail ($5.00 charge applies)

___Via Paper Copy by US Mail ($5.00 charge applies)

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 or Patient or Patient's Authorized Representative Date

_____ _____
Authorized Signature of Facility Date

Spectrum Thermography

Pam Mathews, CCT
480-226-8289
www.spectrumthermography.com

Baseline breast scan	$195.00 - 6 images
Follow up breast scan	$150.00 - 6 images
Womens Health Check	$ 295.00 -18-20 images upper body with isolated views of thyroid and carotid artery
Full Body scan Men or Women	$395.00 -30-36 images
Half Upper Body scan- Men	$295.00 -15 images

Scans are read by E.M.I. Electronic Medical Interpreters. All are MD's certified in reading thermographic scans.

The images and full report are sent directly to you via email within 72 hours or so of scanning.

Within 2 hours before your scan—no hot baths or showers or hot tubs, no deodorants or lotions, no heavy exercise, no spicy foods or gum chewing.