Advanced Patient History and Consent Form

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Patient Information

Name: _____Gender: _____Age: _____ D.O.B: _____

Address: _____

Phone: _____ Email: _____

Occupation: _____ Primary Care Provider: _____ How did you hear about us? _____

Important Notice

InnerLight Thermography LLC does not perform thermography for individuals who are currently pregnant or breastfeeding. Thermography may be provided 90 days postpartum and/or after lactation.

Acknowledgment and Consent

I understand that **InnerLight Thermography LLC** does not provide medical diagnoses but simply acts as the clinical Thermographer-transmitting digital pictures to EMI, a medical digital infrared thermal imaging service. An M.D. will interpret the images and return the images to **InnerLight Thermography LLC**. This evaluation may suggest further medical testing. If further testing is suggested I will consult with my physician or health care provider.

I give my permission for the Clinical Thermographer at **InnerLight Thermography LLC** to take and submit DITI (Digital Infrared Thermal Imagine) images for interpretation. I understand that by doing so, the Clinical Thermographer is not becoming my primary care physician. I understand that a set of thermography pictures and the medical report will be emailed to me so that I can share with my health care practitioner, primary care doctor, or anyone of my choosing.

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report. A doctor-to-doctor consultation can be arranged between EMI and your doctor if necessary.

InnerLight Thermography LLC claims thermography and mammography are two different screening tools and does not claim that one replaces the other.

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

Referring Physician's Name (*if applicable):* _____

Signature (Patient or Guardian): _____ Date: _____

Thermographer Signature: _____ Date: _____

Name: _____Gender: _____Age: _____ D.O.B: _____

Past Illnesses/Surgeries/Injuries/Broken Bones, etc.

Illness/Surgery/Injury	*Year(s)*	*Comments:*

Present Concerns or Symptoms

Concern/Symptom	*Date of Onset*	*Comments/Concerns/Symptoms*

Present Medications:

Medication Name	*Taken For*	*Date Started*

Present Supplements:

Supplement Name	*Taken For*	*Date Started*

Dental Work:

	How Many	*Location*
Fillings Composite (White)/Amalgam (Silver)		
Crowns		
Root Canals		
Wisdom Teeth (Extracted/Intact/Other)		
Implants		
Periodontal Disease/Gum Issues		
Sinus Issues		
Any other Trauma/surgery/issues with mouth/jaw/TMJ/Grinding/Clenching		
Regular Dental Checkups and Cleanings. Yes/No		

General health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor If fair/poor, explain: _____

List location of Piercings/Tattoos/Scars: _____

Name: _____Gender: _____Age: _____ D.O.B: _____

Family Health History

	Circle one	***Cancer History/Type***	***Major Medical Health Problems (Circle** all that apply)*
Mother	Living or Deceased		Stroke, Heart Attack/MI, Diabetes, Hypertension, Other (specify):
Father	Living or Deceased		Stroke, Heart Attack/MI, Diabetes, Hypertension, Other (specify):_____
Other Family	Living or Deceased		Stroke, Heart Attack/MI, Diabetes, Hypertension, Other (specify): _____

Breast Health History

Answer all the following questions (Yes/No):	**Yes**	**No**
1. Family history of breast cancer? Whom?		
2. Personal breast cancer diagnosis? Type of Cancer: Metastatic/Local/Lymph node involvement Date of Diagnosis: _____ Where was/is cancer on the breast: Left/Right UO/UI/LI/LO/Nipple Treatment: Surgery/Chemo/Radiation/None		
3. Past breast conditions? (e.g., fibrocystic, mastitis, cystic, abscess, dense tissue) Condition: _____		
4. Breast biopsies or surgeries? Left/Right Side & Date: _____		
5. Cosmetic surgery or implants? Left/Right Side & Date: _____Implants: Under/Over Muscle, Saline/Silicone		
6. Mammo in last 12 months? Date: _____Results: _____		
7. Mammo in last 5 years? Date: _____ Results: _____		
8. Abnormal results for any breast testing?		
9. Contraceptive pills >1 years? Duration: _____		
10. Gynecologic cancers? Date of diagnosis: _____		
11. Hormone replacement therapy? Pharmaceutical/Bio-Identical		
12. Annual clinical BREAST **exam?**		
13. Self-Breast exam monthly?		
14. How many mammograms in lifetime? _____		
15. Age at first mammogram. _____		
16. Have you ever given birth to a child? # of Live Births YOUR age at first birth # of pregnancies		
17. Did your menstrual cycle start before the age of 12?		
18. Did your menstrual cycle end after the age of 50?		
19. Have you ever smoked/vaped? **Not in last 12 months? _____ Not in last 5 years?_____**		
20. Had a vaccination in the last 4 weeks? Which arm: Left___ Right___		
21. Do you experience hot flashes?		
22. Have you ever been diagnosed with endometriosis?		
23. Have you ever been diagnosed with PCOS (polycystic ovarian syndrome)?		
24. Do you have any swelling in the neck or trouble swallowing?		
25. Do you have any thyroid disorders? (hypo/hyperthyroidism, Hashimoto's/Grave's disease)		

Recent Breast Symptoms	**Subsides after Menstrual Cycle**	**Does Not Subside after Menstrual Cycle**
Pain: Right/Left		
Tenderness: Right/Left		
Lumps: Right/Left		
Change in breast size: Right/Left		
Skin thickening or dimpling: Right/Left		
Nipple discharge: Right/Left		

Patient Information

Name: _____Gender: _____Age:_____ D.O.B: _____

Authorization to Disclose Health Information

As required by the Privacy Regulations, **I*nnerLight Thermography LLC,*** may not use or disclose your protected health information except to communicate said information to EMI to read and for a report to be sent.

I hereby authorize this office and any of its employees to use or disclose my Client Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Client Health Information authorized to be disclosed: ***Thermal Images and related health history*.** For the specific purpose of*:* ***Interpretation of said images*.**

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

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 in the use or disclosure pursuant to this authorization.
2. Have knowledge of any remuneration (money paid for work or a service) involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Client's Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization, however by doing so, we will not be able to provide thermographic services.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with authorization.

I understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility of benefits whether or not I provide authorization to use or disclose protected client health information.

I authorize **InnerLight Thermography LLC** to share my thermal images and health history with EMI (Electronic Medical Interpretations) for the purpose of clinical analysis.

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We can either email a copy of your report, or we can send one via the post office.
Please Mark **ONE:** Email to me: _____ Mail to me + $10 fee: _____ Both + $10 fee _____

Do you want a copy of the thermogram report and images mailed to your doctor? Yes _____ No_____

If Yes, provide your doctor's name and address
(Confirm the correct mailing address for **your** doctor's office. Internet searches are not always accurate.)

Doctor's Name and address: _____

_____

This information is confidential. All information is correct to the best of my knowledge.

Signature (Client or Guardian): _____ Date: _____

Authorized Facility Signature: _____ Date: _____