

**THERMAL MED RX., Inc.**

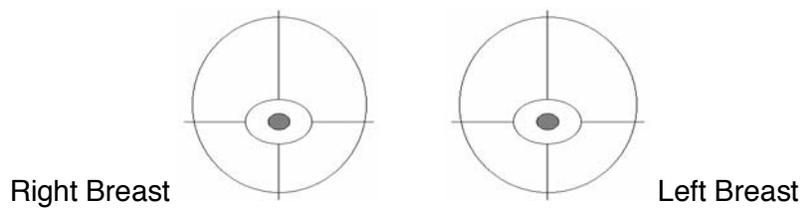
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Fredericksburg, Virginia 22401  
540-368-5558  
[www.ThermalMedRx.com](http://www.ThermalMedRx.com)

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_ **SSN#** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

Do you have any family history of breast cancer?  Self  Mother  Sister  Daughter  None  
*Maternal* –  Grandmother  Aunt  Cousin *Paternal* –  Grandmother  Aunt  Cousin  
Do you have any diagnosed breast conditions?  None  Fibrocystic  Cystic  Other \_\_\_\_\_  
When was the date of your last mammogram? \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Something is being watched –  R  L Breast  
When was the date of your last breast ultrasound? \_\_\_\_\_ Were both breasts imaged?  Y  N  
Was it:  Normal  Abnormal  Suspicious  Something is being watched –  R  L Breast  
Date of last physical breast exam by a doctor \_\_\_\_\_  Normal  Lump found –  R  L Breast  
Any breast biopsies? When and what type (i.e. needle, excisional)? \_\_\_\_\_  R  L Breast  
What was found on the biopsy?  Cancer  Other \_\_\_\_\_  R  L Breast  
Any breast surgeries? When and what was done? \_\_\_\_\_  R  L Breast  
Have you had a mastectomy? If yes, when? \_\_\_\_\_  R  L Breast  
Any breast reconstruction? When and what was done? \_\_\_\_\_  R  L Breast  
If you have had any radiation treatment, when was it last performed? \_\_\_\_\_  R  L Breast  
How many children do you have? \_\_\_\_\_ At what age was your first full term pregnancy? \_\_\_\_\_  
How many of your children did you nurse over 1 month? \_\_\_\_\_ Are you currently nursing?  Y  N  
Are you currently pregnant?  Y  N Current cycle day (number of days since first day of period) \_\_\_\_\_  
If you've used birth control pills, at what age did you start? \_\_\_\_\_ How many years have you taken them? \_\_\_\_\_  
Are you currently taking them?  Y  N If you have passed menopause, at what age did it begin? \_\_\_\_\_  
If you are taking hormone replacement, at what age did you start? \_\_\_\_\_ How many years taken? \_\_\_\_\_  
Are you currently taking hormones?  Y  N (check only if by prescription):  Estrogen  Progesterone  
Are you currently using herbs or supplements to stimulate or simulate estrogen?  Y  N  
Are you currently using any other medications? If yes, what? (i.e. Tamoxifen) \_\_\_\_\_  
Are you currently using a progesterone cream (applied to:  Breasts only  Rotating body areas)  Y  N  
Do you feel that you are overweight? If yes, how many pounds overweight? \_\_\_\_\_  
Have you had your ovaries removed? If yes, at what age? \_\_\_\_\_

**Are you experiencing any of the following with your breasts:**  None  
 A Lump (date found \_\_\_\_\_; by  Self  Doctor. Is it  Hard  Soft  Mobile  Tender)  
Pain:  Dull  Sharp  Burning  Stinging  Tenderness  The pain or tenderness changes with my cycle  
 Thickening  Skin changes ( Color  Texture  Over the lump)  
 R  L Nipple discharge ( Bloody  Milky  Clear  Through 1 duct  Through multiple ducts)  
 R  L Nipple retraction  R  L Nipple Changes ( Color  Texture)  
 Other \_\_\_\_\_

**Place an [ O ] on the diagram in the exact area of the lump, finding on your mammogram, or area being watched, and an [ X ] in the area of pain, tenderness, thickening, or skin changes.**



**Do not write below this line**  Initial Exam  Re-Exam Tech: \_\_\_\_\_  
T = \_\_\_\_\_ F  R  L Nipple retraction  R  L Areola traction toward SLQ SMQ ILQ IMQ  
 R  L Skin surface bulge or dimple SLQ SMQ ILQ IMQ  R  L Skin changes SLQ SMQ ILQ IMQ  
 R  L Nipple Changes ( Color  Texture)  R  L Nipple discharge ( Bloody  Milky  Clear – S M)