HEALINGSPACE
medical center

Confidential Questionnaire

Women's Comprehensive Full Body

Name

Date of Birth: Today's Date:

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.

Head & Neck

	Yes	No
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 from sinus problems?	○	○
11. Do you have a history of dental problems?	○	○
Root canals ____ Gum disease ____ Implants ____		
Non-replaced extractions ____ Dentures ____		
12. Have you had a dental cleaning in the past 7 days?	○	○

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

Breast

Is there a specific reason or concern for this breast exam?

	Yes	No
1. Have you recently had any of these breast symptoms?	○	○

	LT	RT
Pain/Tenderness	○	○
Lumps	○	○
Change in breast size	○	○
Areas of skin changes thickening or dimpling	○	○
Excretions of the nipple	○	○

	Yes	No
2. Are any of the above symptoms cycle-related?	○	○
3. Are you still having periods?	○	○

If yes, date of last period

4. Have you had a surgical hysterectomy?	○	○

If yes, date ○ Complete ○ Partial

Reason for hysterectomy:
○ Excess bleeding ○ Endometriosis ○ Fibroid cysts ○ Cancer ○ Other _____

5. Has anyone in your family ever been treated for breast cancer?	○	○

If yes, ○ Mother ○ Grandmother ○ Sister ○ Daughter
Age diagnosed _____ Result of Treatment_____

6. Have you ever been diagnosed with breast cancer?	○	○

If yes, date:

Cancer type ○ Local ○ Metastatic ○ Lymph node involvement

Left breast ○ Inner ○ Outer ○ Nipple

Right breast ○ Inner ○ Outer ○ Nipple

Treatment ○ Surgery ○ Chemo ○ Radiation ○ None

7. Have you ever been diagnosed with any other breast disease?	○	○

If yes, ○ Cysts/fibrocystic ○ Fibro Adenoma ○ Mastitis/inflammatory breast disease

	Yes	No
8. Have you had any cosmetic breast surgery or implants?	○	○
If yes, date ○ Silicone ○ Saline		
Experience ○ Problems ○ No problems		
9. Have you ever had any biopsies or any other surgeries to your breasts?	○	○
If yes, date		
Left breast ○ Inner ○ Outer ○ Nipple		
Right breast ○ Inner ○ Outer ○ Nipple		
Results ○ Negative ○ Positive ○ Calcifications		
10. Have you ever taken contraceptive pills for more than one year?	○	○
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years		
11. Have you had pharmaceutical hormone replacement therapy (HRT)?	○	○
If yes, ○ Currently ○ Less than 5 years ○ More than 5 years		
12. Do you have an annual physical examination by a doctor?	○	○
13. Do you perform a monthly breast self-exam?	○	○
14. Have you ever smoked?	○	○
15. Have you ever been diagnosed with diabetes?	○	○
16. Total Mammograms _____		
17. Date of your last mammogram Were you re-called?	○	○
18. Your age at your first mammogram?		
19. Number of full-term pregnancies?		
20. Have you had breast ultrasound?	○	○
If yes…Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____		
21. Have you had breast MRI?	○	○
If yes…Date:____/____ Left _____ Right_____ Results: Negative____ Positive ____		

Chest, Heart & Lungs

	Yes	No
1. Have you been diagnosed with:		
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?	○	○

	Yes	No
6. Do you currently smoke?	○	○
7. Have you smoked in the past 5 years?	○	○

Abdomen & Lower Back

	Yes	No		Yes	No
1. Do you suffer from acid reflux or other digestive problems?	○	○	Have you had surgery or disease in the:		
2. Do you suffer pain in the:			Stomach?	○	○
Stomach?	○	○	Spleen(Upper Left) ?	○	○
Below R Breast?	○	○	Liver(Upper Right) ?	○	○
Below L Breast?	○	○	Kidneys?	○	○
Abdomen?	○	○	Intestines?	○	○
Lower Back?	○	○	Abdomen?	○	○
Pelvic Region?	○	○	Lower Back?	○	○
			Pelvic Region?	○	○

Have you consumed alcohol in the past 24 hours?	○	○

Legs & Feet

Check only if "Yes."

1. Do you suffer pain in the:	LT	RT	2. Have you had Surgery to:	LT	RT
Leg?	○	○	Leg?	○	○
Sciatica?	○	○	Sciatica?	○	○
Buttocks/Hip?	○	○	Buttocks/Hip?	○	○
Knees?	○	○	Knees?	○	○
Ankles?	○	○	Ankles?	○	○
Feet?	○	○	Feet?	○	○

Arms & Hands

(Check only if "yes")

1. Do you suffer from pain in the:	**LT**	**RT**	**2.** Have you had surgery to:	**LT**	**RT**
Shoulder?	○	○	Shoulder?	○	○
Elbow?	○	○	Elbow?	○	○
Arm?	○	○	Arm?	○	○
Hands?	○	○	Hands?	○	○

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