



# Thermography Clinic Milton Inc.

400 Bronte Street S., Suite 215

Milton, Ontario L9T 0H7

(905) 781-2447

Date of previous exam:

Right Breast Score:

Left Breast Score:

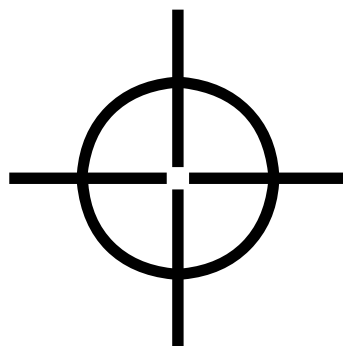
Name:

Date of Birth    mm /    dd /    yyyy Date of Exam: mm / dd / yyyy

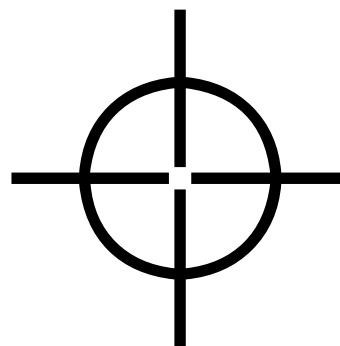
## SINCE YOUR LAST THERMOGRAM HAVE YOU:

- Y  N Been diagnosed with any breast conditions?  
 None  Fibrocystic  Cystic  Other \_\_\_\_\_
- Y  N Had a mammogram? If so please provide date \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast
- Y  N Had any breast ultrasounds? If so please provide date \_\_\_\_\_  
Was it:  Normal  Abnormal  Suspicious  Being watched  R  L Breast
- Y  N Had a breast exam by a doctor? If so please provide date \_\_\_\_\_  
Was it:  Normal  Lump Found  R  L Breast
- Y  N Had any breast biopsies, surgeries, procedures or other forms of screening to your  
breasts since your last thermogram? If So, When and what type \_\_\_\_\_  
\_\_\_\_\_  R  L Breast

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.



RIGHT BREAST



LEFT BREAST

Please note any other concerns/issues that might have risen since your last thermogram: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_