Breast Health History

Imaging Center_____

Patient Email: _____

Name:_____Age:_____ Date of Scan: _____

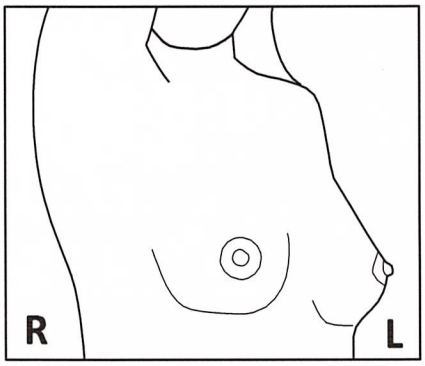
Date of Birth:_____Sex: F ☐ M ☐ Initial Scan ☐ Follow-up Scan ☐

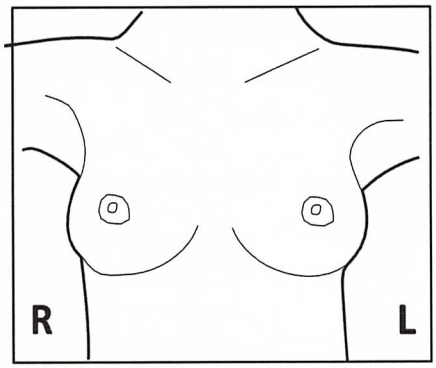
Describe any current breast concerns such as lumps, pain, skin changes, radiographic findings or other concerns:

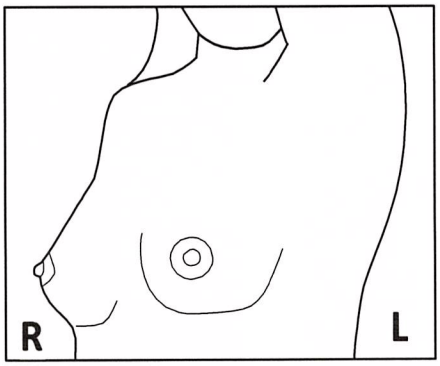
_____

_____

MARK THE AREA OF ANY CURRENT CONCERN ON THE DIAGRAM:







_____ _____ _____

_____ _____ _____

Last Physical Breast Examination by a Health Care Provider: ☐ None

Date: _____ Results: ☐Normal Other_____

Last Mammogram: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐Normal Other_____

Last Breast Ultrasound: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐Normal Other_____

Last Breast MRI: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐ Normal Other_____

Breast Biopsy: ☐ None

Date: _____ ☐ Right ☐ Left ☐ Both

Results: ☐ Benign ☐ Pre-Cancer ☐ Cancer

Section 1: Breast Cancer ☐ None ☐ Left ☐ Right ☐ Both Date of Diagnosis:_____

Cancer Treatment:

☐ Lumpectomy: Date:_____ ☐ Mastectomy: Date: _____

☐ Reconstruction: Date: _____ ☐ Radiation treatment: Date of last treatment _____

Other treatment _____

Section 2: General

Benign Breast Surgery: ☐ None Lumpectomy: Date:_____ ☐ Right ☐ Left

Implants: Date:_____ Reduction: Date:_____

Fibrocystic breasts, Breast Cysts, or General Breast Lumpiness ☐Yes ☐ No

Other benign breast conditions: ☐ None ☐ Yes _____

Currently Breast feeding: ☐No

☐ Yes - Last Breast Nursed: ☐ Right ☐ Left Breast Most Favored: ☐ Right ☐ Left

Pregnant: ☐Yes ☐ No - current cycle day (# of days since 1st day of period):_____

Menopause:☐ No ☐ Yes - Age of last menses: _____

Currently experiencing symptoms of: ☐Menopause ☐ Perimenopause ☐ Neither

Both ovaries removed: ☐ Yes - Check only if both have been removed ☐ No

Family history of breast cancer: ☐ Yes ☐ No

Past injury to the breasts: ☐None ☐ Right ☐ Left ☐ Both Date of Injury:_____

Section 3: Selected Hormones and Factors Effecting Them

Current Hormones: ☐ None

☐ Estrogen ☐ Progesterone ☐ Testosterone ☐Thyroid hormone

Current supplements to support the following: ☐ None

☐ Breast Health ☐ Hormonal Balance ☐Inflammation ☐Thyroid Function

Are you currently engaged in any lifestyle activities or diet designed to: ☐ None

☐ Promote breast health ☐ Reduce inflammation ☐ Promote hormonal balance

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PLEASE DO NOT WRITE IN THIS SECTION

Tech:_____Patient Temp:_____F Laboratory Temp:_____C

INFORMED CONSENT FOR TESTING PROCEDURE

Thermal Breast Imaging (otherwise known as breast thermography) detects and visualizes the thermal emissions (temperature) occurring at the surface of the breasts. The purpose of the examination is to detect signs of inflammation or unusual blood vessel activity that could suggest risk for current and/or future risk for cancer. Initial ____

I understand that Thermal Breast Imaging is used only as an adjunct to primary screening examinations such as physical breast examination, mammography, breast ultrasound and breast MRI and does not replace any other breast examination or screening. I also understand that thermal imaging does not and cannot directly detect or be used to diagnose breast cancer. Nor can it rule out the presence of breast cancer since some cancers do not produce sufficient temperature changes at the surface of the breasts to be seen with thermography. Therefore, breast cancer may still be present despite thermal imaging revealing a low risk. For that reason, thermal imaging does not replace any other breast examination. All breast concerns including but not limited to skin changes, nipple discharge, lumps or other abnormalities, clinical findings and radiographic findings require evaluation by a medical doctor regardless of the thermal imaging results. Use of thermography as a stand-alone detection examination is not recommended as it can result in the failure of an existing cancer to be detected. Initial _____

I confirm that I have followed the written pre-examination protocols for breast imaging provided to me before the examination. I understand that if I did not receive or follow these protocols, the accuracy of my examination may be compromised. Initial _____

By signing below, I hereby acknowledge that (1) I have read and understood each of the above paragraphs; (2) I have had an opportunity to ask any questions I may have had; (3) any questions I asked were answered to my satisfaction; (4) I have received sufficient information with respect to thermal imaging to make an informed decision to undergo the procedure; (5) I understand no guarantee or warranty is being made that all risk for current and/or future cancer will be detected; and (6) I hereby authorize and consent to thermal imaging

_____	_____	_____
Print Name	Signature	Date

STATEMENT OF INDEPENDENT OPERATIONS:

I understand and agree that Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services (collectively referred to as "Kane Interpretive Services") is a California based company that contracts with the provider of your imaging services solely for the purpose of interpreting and reporting thermal imaging scans. Your provider is not an employee, officer, director, partner, representative or agent of Kane Interpretive Services. Nor is Kane Interpretive Services an employee, officer, director, partner, representative or agent of your provider. Kane Interpretive Services is a wholly separate business entity from your provider and does not oversee or supervise your provider's thermography operations. Kane Interpretive Services is not involved in the design, manufacture, marketing, sale, rental, distribution, installation, inspection, repair or modification of any machinery or products used by your provider. Rather, Kane Interpretive Services is an independent contractor hired by your provider solely to interpret thermal imaging data and to report the results. Kane Thermal Interpretive Services does not control, nor have the right to control, your provider's business, including its equipment, operations, advertising and/or representations. Kane Interpretive Services makes no promises, warranties or representations, express or implied, as to your provider's services. In addition, Kane Interpretive Services owes no duty of care to me in connection with provider's services, including no duty to screen provider, no duty to protect or warn me of any actions or inactions of provider and no duty to investigate, communicate or mitigate any risks, known or unknown, relating to provider's services. I assume all duty of reasonable care to select, screen and monitor provider's services for my own safety and protection.

By signing this Statement of Independent Operations, I understand and agree with the foregoing and further agree that Dr. Robert L. Kane, D.C., D.A.B.C.T., dba Kane Thermal Imaging Interpretive Services is only responsible to me for the content of the thermal imaging report and its accompanying reporting guide.

_____	_____	_____
Print Name	Signature	Date

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Digestive Tract	Nausea, vomiting	⓪ ① ② ③ ④
	Diarrhea	⓪ ① ② ③ ④
	Constipation	⓪ ① ② ③ ④
	Bloated feeling	⓪ ① ② ③ ④
	Heartburn	⓪ ① ② ③ ④
	Intestinal, stomach pain	⓪ ① ② ③ ④
	Digestive Total:	
Joints / Muscles	Pain or aches in joints	⓪ ① ② ③ ④
	Arthritis, joint swelling	⓪ ① ② ③ ④
	Stiff or limitation of movement	⓪ ① ② ③ ④
	Pain or aches in muscles	⓪ ① ② ③ ④
	Feeling of weakness or tired	⓪ ① ② ③ ④
	Joints / Muscles Total:	
Emotional	Mood swings	⓪ ① ② ③ ④
	Anxiety, fear, nervousness	⓪ ① ② ③ ④
	Anger, irritability, aggression	⓪ ① ② ③ ④
	Depression	⓪ ① ② ③ ④
	Emotional Total:	
Weight / Food	Binge eating, drinking	⓪ ① ② ③ ④
	Craving certain foods	⓪ ① ② ③ ④
	Excessive weight	⓪ ① ② ③ ④
	Compulsive eating, food addictions	⓪ ① ② ③ ④
	Water retention	⓪ ① ② ③ ④
	Underweight	⓪ ① ② ③ ④
	Weight / Food Total:	
Energy / Sleep	Fatigue, sluggishness	⓪ ① ② ③ ④
	Apathy, lethargy	⓪ ① ② ③ ④
	Hyperactivity	⓪ ① ② ③ ④
	Restlessness, achiness	⓪ ① ② ③ ④
	Sleep disturbances	⓪ ① ② ③ ④
	Energy / Sleep Total:	
Skin	Acne	⓪ ① ② ③ ④
	Hives, rashes, dry skin, redness	⓪ ① ② ③ ④
	Hair loss	⓪ ① ② ③ ④
	Flushing, hot flashes	⓪ ① ② ③ ④
	Excessive sweating	⓪ ① ② ③ ④
	Skin Total:	
Heart	Irregular or skipped heartbeat	⓪ ① ② ③ ④
	Rapid or pounding heartbeat	⓪ ① ② ③ ④
	Chest pain	⓪ ① ② ③ ④
	Heart Total:	
Other	Frequent illness	⓪ ① ② ③ ④
	Frequent or urgent urination	⓪ ① ② ③ ④
	Genital itch or discharge	⓪ ① ② ③ ④
	Other Total:	

Respiratory	Chest congestion	⓪ ① ② ③ ④
	Asthma, bronchitis	⓪ ① ② ③ ④
	Shortness of breath	⓪ ① ② ③ ④
	Difficulty breathing	⓪ ① ② ③ ④
	Respiratory Total:	
Eyes	Watery or itchy eyes	⓪ ① ② ③ ④
	Swollen, red, or sticky eyelids	⓪ ① ② ③ ④
	Bags or dark circles under eyes	⓪ ① ② ③ ④
	Blurred or restricted vision	⓪ ① ② ③ ④
	Eyes Total:	
Nose	Stuffy nose	⓪ ① ② ③ ④
	Sinus problems or dripping nose	⓪ ① ② ③ ④
	Hay fever	⓪ ① ② ③ ④
	Sneezing attacks	⓪ ① ② ③ ④
	Excessive mucus	⓪ ① ② ③ ④
	Nose Total:	
Mouth / Throat	Frequent, consistent coughing	⓪ ① ② ③ ④
	Gagging, need to clear throat	⓪ ① ② ③ ④
	Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④
	Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④
	Canker sores, other mouth sores	⓪ ① ② ③ ④
	Mouth / Throat Total:	
Ears	Itchy ears	⓪ ① ② ③ ④
	Earaches, ear infections	⓪ ① ② ③ ④
	Drainage from ear, waxy buildup	⓪ ① ② ③ ④
	Ringing in ears, hearing loss	⓪ ① ② ③ ④
	Ears Total:	
Head	Headaches	⓪ ① ② ③ ④
	Faintness or lightheadedness	⓪ ① ② ③ ④
	Dizziness	⓪ ① ② ③ ④
	Head Total:	
Cognitive	Poor memory, recall	⓪ ① ② ③ ④
	Confusion, poor comprehension	⓪ ① ② ③ ④
	Poor concentration	⓪ ① ② ③ ④
	Poor physical coordination	⓪ ① ② ③ ④
	Difficulty in making decisions	⓪ ① ② ③ ④
	Stuttering, stammering	⓪ ① ② ③ ④
	Slurred speech	⓪ ① ② ③ ④
	Learning disabilities	⓪ ① ② ③ ④
	Cognitive Total:	

Grand Total _____

For Practitioner Use Only:

Urinary pH_____

Metagenics®

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
◯ Yes (1 pt.) ◯ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?
◯ Cimetidine (2 pts.) ◯ Acetaminophen (2 pts.) ◯ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
◯ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
◯ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
◯ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
◯ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently (within the last 6 months) or have you regularly used tobacco products?
◯ Yes (2 pts.) ◯ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
◯ Yes (1 pt.) ◯ No (0 pt.)

7. Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

10. Do you have a personal history of:
◯ Environmental and/or chemical sensitivities (5 pts.)
◯ Chronic fatigue syndrome (5 pts.)
◯ Multiple chemical sensitivity (5 pts.)
◯ Fibromyalgia (3 pts.)
◯ Parkinson's type symptoms (3 pts.)
◯ Alcohol or chemical dependence (2 pts.)
◯ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
◯ Yes (1 pt.) ◯ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?
◯ Yes (1 pt.) ◯ No (0 pt.) ◯ Don't know (0 pt.)

Total _____

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction?
◯ Yes (1 pt.) ◯ No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?
◯ Yes (1 pt.) ◯ No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?
◯ Yes (1 pt.) ◯ No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High ›50; moderate 15-49; low ‹14)
Part 2: XTT Total _____ (High ›10; moderate 5-9; low ‹4)
Part 3: Alkalizing Assessment Total _____ (High ≥1)
Urinary pH _____

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.

ADVANCED HEALTH
NATURAL HEALTH IMPROVEMENT CENTER

NAME: _____ DATE: _____

Daily Medication List

My Medication List

Include your prescription & over the counter medications as well as natural supplements.

Medications	Taken for	Dose	Frequency	Times Taken				Date Stopped

My primary medical doctor is: _____

My primary natural health practitioner is: _____