



Dr. Natalie Yahle, DC, CTT  
American Academy of Thermology Certified Physician Member

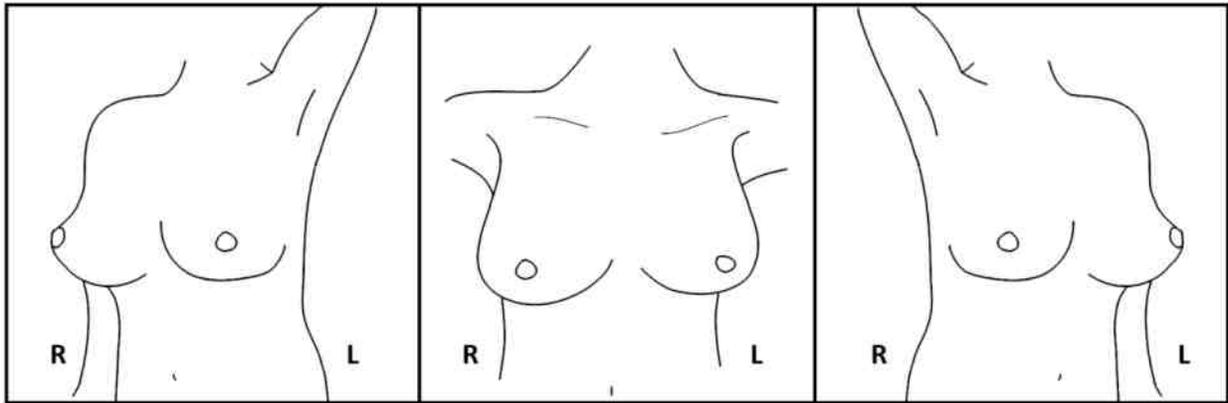
**Breast Health History Form**

Date of Scan: \_\_\_\_\_  Initial  Follow Up

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

List the location and describe any breast concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mark on the diagram(s) below where the concern is:



Date of last physical breast exam by your healthcare provider: \_\_\_\_\_

Findings: \_\_\_\_\_  
\_\_\_\_\_

Date of last mammogram \_\_\_\_\_  Normal  Abnormal:  R  L

Result \_\_\_\_\_  
\_\_\_\_\_

Do you have dense breasts:  Y  N  Unsure

Date of last breast ultrasound \_\_\_\_\_  Normal  Abnormal:  R  L

Result: \_\_\_\_\_  
\_\_\_\_\_

Date of last breast MRI \_\_\_\_\_  Normal  Abnormal:  R  L

Result: \_\_\_\_\_  
\_\_\_\_\_



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Have you ever had a biopsy? Date: \_\_\_\_\_ Location on breast:  R  L  Both

Result: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been diagnosed with breast cancer?  Y  N Date: \_\_\_\_\_

Diagnosis:  Right Breast  Left Breast  Both

\_\_\_\_\_  
\_\_\_\_\_

Do you have a family history of breast cancer?  Y  N

Please check any breast surgeries you have had and list the date of the surgery:

Lumpectomy? Date: \_\_\_\_\_  Right breast  Left breast  Both

Mastectomy? Date: \_\_\_\_\_  Right breast  Left breast  Both

Was the nipple removed?  Y  N

Breast reconstruction?  R side  L side

Breast implants?  Y  N  Right breast  Left breast  Both

Breast reduction?  Y  N

Do you have a history of breast radiation treatments?  Y  N  R side  L side  Both

Date: \_\_\_\_\_

Do you have any inverted nipples?  Y  N  R side  L side  Both

Are you experiencing any nipple discharge?  Y  N  R side  L side Describe: \_\_\_\_\_

Have there been any injuries to the chest wall or breasts?  Y  N Describe: \_\_\_\_\_

Are there any skin changes, rashes, or scars on the chest wall or breasts?  Y  N

Describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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Date of last menstrual cycle: \_\_\_\_\_

Are you pregnant?  Y  N    Are you currently breastfeeding?  Y  N

Are you on birth control or hormone replacement therapy?  Y  N

Describe:

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List any essential oils you use: \_\_\_\_\_

Do you eat or use any of the following more than 3 times per week:

- Tofu, edamame, tempeh, Soy Supplements and/or Soy based protein powders
- Drink cow's milk, eat cheese or use a whey based protein powder
- Flax seeds
- DHEA supplements, Black cohosh or supplements for hot flashes/menopause

List any medications you are currently on: \_\_\_\_\_

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List any supplements you are currently taking: \_\_\_\_\_

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**Office use only**

Technician: \_\_\_\_\_ Room Temp: \_\_\_\_\_ °C Patient Temp: \_\_\_\_\_



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## Informed Consent

I, \_\_\_\_\_ acknowledge that the American Academy of Thermology  
(PRINT NAME)  
Internationally peer reviewed guidelines state the following in regards to infrared breast imaging:

“Thermal imaging is an examination of physiology that is complementary to anatomical imaging techniques. Though proven to be highly accurate, thermal imaging is an adjunctive procedure; and as such, it is not intended to replace anatomic studies such as mammography, ultrasound, MRI, CT, X-ray, or others.” \_\_\_\_\_

(INITIAL)

“Thermography utilizes infrared technology which does not see into the body. It does not image any structure deeper than the skin or superficial mucosa. The technology detects heat and measures temperature. A normal thermographic study does NOT necessarily indicate that there is no abnormality and an abnormal study should only be considered as a risk marker. Infrared imaging can only be considered as one part of the evaluative process.” \_\_\_\_\_

(INITIAL)

I have followed all pre-examination requirements that comply with the AAT internationally peer reviewed guidelines. I understand that failure to comply with the protocols set forth in the guidelines can compromise the examination. \_\_\_\_\_

(INITIAL)

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date