Early Breast Screen
916-784-9355

PRE-SCREENING INSTRUCTIONS

Name: ____________________________________ Date: ______________

By carefully following the instructions below and accurate reading can be obtained at the time of your screening. If you cannot meet any of the criteria listed below, please call the office to receive further instructions.

Thank you for your cooperation in helping us to perform accurate screening for you.

I have had no prolonged sun exposure to the chest and breast area 5 days prior to the scan, I have not been tanning, have not used tanning sprays and I do not have a fever today.

I have not used any lotions, creams, powders, or makeup on the breasts, and I have not used any deodorant or antiperspirant.

I did not shave or use other types of hair removal of the chest, breasts, or underarms 24 hours prior to the scan.

I have had no chiropractic, acupuncture, TENS, physical therapy, electrical muscle stimulation, ultrasound, massage therapy with analgesic use, creams, balms, hot or cold pack use of the neck, back, chest or breasts for 24 hours prior to scan. I have not had a mammogram or breast exam for 24 hours prior to scan.

I have avoided physical stimulation of the breasts, nipples, underarms, and chest, including sexual activity involving the breasts for 24 hours prior to scan.

I have not bathed, showered or soaked in hot water, including a sauna or hot tub for at least 4 hours prior to my thermogram appointment.

I have not performed any rigorous exercise for at least four hours prior to my appointment.

I had no caffeinated beverages, including coffee, tea, soda or other beverages containing caffeine and no alcohol for at least four hours prior to my scan. Chocolate contains caffeine.

I did not smoke cigarettes, chew tobacco or use any product which contains nicotine. Please avoid nicotine the day of your scan.

If you are nursing, please try to nurse as far from one hour prior to your scan as possible and nurse evenly on both sides 24 hours prior to your appointment.

If you are taking pain medications, please avoid taken them for four hours prior to the scan, especially vasoactive drugs, if not contraindicated by your health care practitioner.

Have you had any radiation treatments in the last six months? _____ Yes _____ No

I certify that I have complied with the above instructions and have check off each box indicating I have done so. I understand my appointment may need to be rescheduled if any of the above criteria has not been met.

Signature: ____ Date: __________________