DEAR BODY SCAN INTERNATIONAL PATIENT

Thank you for scheduling your Body Scan examination. We are committed to providing you with outstanding service, along with our revolutionary diagnostic technology.

There are a few "do's and don'ts" regarding your appointment.

DO:

- Expect a **confirmation call** from us five (5) business days before your appointment. At the time of the confirmation call, please be prepared to give us a credit card number in order to hold your reservation. This number will be kept in a confidential, secure database. As our time slots are limited, it is essential that we have confirmation. **If you are going to be unavailable by telephone, please check in with us to confirm. The confirmation telephone line is (888) 724-8439.** If we have not heard from you, our policy is to fill the slot with a patient from our waiting list. This policy was adopted in order to keep the scheduling wait to a minimum. **Please note that we do require a minimum of two business days notice for the cancellation of a confirmed appointment. If you fail to give us the required notice on a cancellation, there is a non-refundable $200 late cancellation fee.**
- Wear a comfortable two-piece outfit. Ladies, please wear a bra without metal attachments. If you do not have one, you will be asked to remove your bra before the scan. Please do not apply any lotions or powder to the chest area the day of your appointment.
- **Anticipate a visit lasting approximately 3-4 hours**. Upon your arrival, your paperwork will be collected, and we will review the consent form with you. You will then be led to the testing area, where the scan will be performed. The scan will take approximately 10 minutes. At the conclusion of the scan, you will be placed in a private room, where you will see an informative, detailed video regarding the test. You will then be informed of the approximate time until the consultation (there is often a gap between the scan and the consultation ranging from 1 – 2 hours). During this gap, you will typically have a chance to eat and drink.
- We consider the **private consultation** with our physician an essential part of the Body Scan experience. The consultation is a time when you are taken on a 3-Dimensional tour of your body. The consultations take approximately 30-45 minutes. Please keep in mind that we cannot allow small children to attend the consultation, nor are we able to care for children during your consultation.
- One copy of the Body Scan report will be mailed to each patient. If you have a prescription, you will receive one copy, and your physician will receive one copy. In most instances, you will receive your report in 4-6 weeks. ***Please*** consider this timeframe when scheduling an appointment with your personal physician. Conventional x-ray films are not available.

DON'T:

- **Do not have any solid food for eight hours. Don't eat or drink (including water) for six hours prior to the examination.**
- **Do not urinate for two hours before the scan. This allows our physician to better evaluate your bladder.**
- **Don't be nervous. The Body Scan test is conducted in a relaxed personalized atmosphere.**

We are here to provide a healthcare experience unlike any you have ever experienced. Our staff is experienced and here to be of assistance. Please understand that as a healthcare provider, we come across many variations in patient condition. These variations can make our schedule unpredictable at times.

Early Disease Detection: While the annual physical is still important, Body Scan Internationals' early detection system can uncover asymptomatic and often life-threatening disease generally not detectable by physical exam or standard screening tests. This allows for management of disease at earlier stages, where medical therapy and treatment options are less costly and less invasive. We look from the top of the neck to the pelvis, checking the structure of your bones and organs.

Please note the following important information regarding the Body Scan examination:

- While this test does not measure blood flow, it does provide an early detection device for calcified plaque development in the coronary arteries. Plaque is a complex substance that can grow in the artery. Measuring the amount of calcific plaque is a good early indicator for the risk of heart attack.
- We provide a high-resolution scan of the lungs, providing early detection well beyond the chest x-ray.
- This examination complements, but does not replace, a mammogram.
- We visualize the stomach with virtual gastroscopy and look for structural abnormalities, masses, cancer, and polyps. **The colon and small intestine are not well-visualized on the standard Body Scan exam.**
- In the gallbladder, we will typically detect gallstones that have calcified. Gallstones without calcification are harder to detect and may not be visualized.
- Our 3-Dimensional software allows us to virtually take apart the spine, detecting disc bulges, structural abnormalities, and measure bone density utilizing QCT (Quantitative Computerized Tomography).
- Visualization of the ovaries is dependent on the individual anatomy of the patient.
- While this test will look at the prostate gland, we will not be able to detect very early abnormalities. This test should not be used as a replacement for the PSA test.
- This test should not be used for follow-up of metastatic disease.

This is an early screening test to help locate potential problems before they become serious. This information can put you on track toward stopping, slowing, or preventing later problems. Questions regarding the medical appropriateness of our test for specific symptoms should be addressed to your personal physician.

Thank you again, and we look forward to serving you.

Body Scan International
Tel. 888.724.8439 / 877-274-5577

20162 SW Birch Street Suite 100
Newport Beach, CA 92660

PATIENT INFORMATION

Patient Name: _____ Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

MAILING ADDRESS: _____ City: _____ State: _____ Zip: _____

Home Telephone #: ( ) _____ Second Telephone #: ( ) _____

Email address: _____ Marital Status: S___ M___ D___ W___

Birth Date: _____ Age:_____ Height: _____ Weight: _____

How did you hear about us?_____ If from prior patient, Name: _____

In emergency contact: _____ Tel. #: ( )_____

PHYSICIAN INFORMATION

Name:_____ Telephone #: ( ) _____

Address: _____ Fax #: ( ) _____

City:_____ State: _____ Zip: _____

OCCUPATION INFORMATION

Employer: _____ Title /Position: _____ How Long: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: ( ) _____ Second #: ( ) _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Ins. Co. Name: _____	Ins Co. Name: _____
Billing Address: _____	Billing Address: _____
Ins Co Telephone #: ( )_____	Ins. Co. Telephone #: ( ) _____
Cert/ID No: _____	Cert/ID No: _____
Group/Policy #: _____	Group/Policy #: _____
Name of Insured: _____DOB: _____	Name of Insured: _____DOB: _____
Insured Soc. Sec. #: _____	Insured Soc. Sec. #: _____
Relationship to Patient: _____	Relationship to Patient: _____

Patient ID: _____
Date of Birth: _____

HEALTH HISTORY AND BEHAVIORS QUESTIONNAIRE

Body Scan International is dedicated to providing a non-invasive early disease detection system with your optimal health and longevity in mind. The following Health History and Behaviors Questionnaire will enable us to be the best partners we can on this pathway to optimal health. We would like you to take some time before your visit to our Center to complete this questionnaire and bring it with you to your appointment at Body Scan International. Your information will remain confidential.

WOMEN ONLY: IF YOU ARE OR THINK YOU ARE CURRENTLY PREGNANT, PLEASE NOTIFY THE RECEPTIONIST IMMEDIATELY

Health History:

Height:_____ Weight:_____Gender: Male ○ Female ○

1. Date of last stress test:_____ Type? EKG □ ECHO □ THALLIUM/ CARDIOLYTE □

2. Date of last mammogram:_____

3. Allergies to medications:_____

4. Have you had any surgeries? If so please list:
_____ Date:_____
_____ Date:_____
_____ Date:_____

5. What is your main reason for having this test?
_____
_____

6. Do you have pain in any of these areas:

Neck:	θ	Yes
	θ	No
Lower Back:	θ	Yes
	θ	No
Abdominal Pain:	θ	Yes
	θ	No
Pelvic Pain:	θ	Yes
	θ	No

Other Pain Describe:_____

7. Has your doctor ever told you that you have (or had) angina (chest pain generally provoked upon exertion, relieved upon rest)?
   θ Yes
   θ No
   θ Not sure

8. If so, do you currently have (e.g. weekly or more frequent) such chest pain?
   θ Yes
   θ No

9. Has your doctor ever told you that you have had a heart attack?
   θ Yes
   θ No
   θ Not sure

10. If so, when did your heart attack(s) occur (month, year), and where were you hospitalized?
    Date_____
    Hospital_____City_____State___

    Date_____
    Hospital_____City_____State___

11. Have you ever had heart bypass surgery?
    θ Yes
    θ No

12. If yes, please list date(s) and hospital(s) where performed:
    Date_____
    Hospital_____City_____State___

13. Have you ever had a balloon angioplasty of the heart (PTCA)? Indicate if:
    θ Yes
    θ No
    θ Atherectomy
    θ Stent
    θ Not Sure

14. If yes, please list date(s) and hospital(s) where performed :
    Date_____
    Hospital_____City_____State___

15. Have you ever had surgery to remove blockage from blood vessels in you neck or legs?
    θ Yes
    θ No

16. If yes, please describe surgery and list date(s) and hospital(s) where performed:
    Date_____
    Hospital_____City_____State____

17. Have you ever had any other type of heart disease (e.g. heart valve disease, heart failure, abnormal heart rhythms such as atrial fibrillation)?
    θ Yes
    θ No

18. If yes, please describe the condition(s) the best you can, and approximate the day it (they) began or were diagnosed:

Condition_____

_____

Date began or diagnosed_____

19. Has your doctor ever told you that you have had a stroke? θ Yes θ No

20. If so, when did your stroke(s) occur (month, year), and where were you hospitalized?

Date_____
Hospital_____City_____State_____

Date_____
Hospital_____City_____State_____

Date_____
Hospital_____City_____State_____

21. Were you ever told by your doctor that you had a "mini stroke" or transient ischemic attack? θ Yes θ No

22. Has a doctor ever told you that you have any of the other following conditions?

Migraine Headaches	_____	Pulmonary/Lung disease	_____
Stomach ulcers	_____	Rheumatological/Musculoskeletal	_____
Arthritis	_____	Endocrine disorder	_____
Osteoporosis	_____	Liver disease	_____
Gastrointestinal disorder	_____	Drug abuse/addiction	_____
Allergies	_____	Psychiatric	_____
Kidney disease	_____	Reproductive disorder	_____
Phobia, Panic Attack	_____	Seizure	_____

Other: _____

23. If any of the above is checked, please describe: _____

_____

_____Duration_____

24. Have you been diagnosed with cancer? θ Yes θ No

25. If yes, what type or location? _____

26. Has your doctor ever told you that you have high blood pressure (or "hypertension")? θ Yes, currently θ Yes, in the past only θ No, never

27. If yes, please list medication(s) that you are <u>currently</u> taking for your high blood pressure (if none, state "none"): _____

_____

28. Has your doctor ever told you that you have high cholesterol or triglycerides?
θ Yes, currently
θ Yes, in the past only
θ No

29. If yes, please list medication(s) that you are currently taking for your blood cholesterol or triglycerides (if none, state "none"): _____

30. Has your doctor ever told you that you have diabetes?
θ Yes
θ No
θ Not sure

31. If yes, at what age did you first learn you had diabetes? Age: _____

32. Are you currently taking insulin to control your diabetes?
θ Yes
θ No

33. If you are currently taking other medications for your diabetes, please list them:_____
_____

Risk Factors

34. Have you smoked 100 cigarettes or more in your lifetime?
θ No
θ Yes, currently
smoke
θ Yes, in the past, quit

35. If you quit, at what age did you quit? Age: _____

36. If currently/previously smoking, how many cigarettes, on average, do/did you smoke per day? _____cigarettes
For approximately how many years? _____years

37. Did any parent or sibling (or blood related uncle/aunt) have a history of any of the following? Please indicate by completing the following:

	Family member(s)	Age first occurrence
Heart attack:	_____	_____
Angioplasty or bypass surgery:	_____	_____
Diabetes:	_____	_____
Cancer (specify):_____	_____	_____

38. Are you currently, or have you previously, taken aspirin?
θ Yes, every day or almost every day
θ Yes, about every other day
θ Yes, occasionally
θ No, never

39. If yes, for what reason(s) (check all that apply):

θ Only for aches and pains, including headaches
θ To prevent heart attacks, other heart disease, strokes
θ Other reasons (write these in):_____

40. If yes, when do you take aspirin, how much do you take in one day?

θ Less than one "baby aspirin"
θ One "baby aspirin"
θ One adult aspirin
θ Two or more adult aspirins

41. The next questions provide a simple way to measure how many servings of fruit and vegetables you normally eat. Please blacken in the answer showing how often you ate or drank each of these foods in the past month. (Please blacken only 1 answer for each item.)

		Never	1-3 times per month	1-2 times per week	3-4 times per week	5-6 times per week	1 time per day	2 times per day	3 times per day	4 times per day
a.	100% orange juice or grapefruit juice fruit drinks	θ	θ	θ	θ	θ	θ	θ	θ	θ
b.	Green salads (with or without other vegetables)	θ	θ	θ	θ	θ	θ	θ	θ	θ
c.	French fries or fried potatoes Baked boiled or mashed potatoes	θ	θ	θ	θ	θ	θ	θ	θ	θ
d.	About how many servings of vegetables did you eat, not counting salad or potatoes	θ	θ	θ	θ	θ	θ	θ	θ	θ
e.	About how many servings of fruit did you eat, not counting juices	θ	θ	θ	θ	θ	θ	θ	θ	θ

Are you currently or have you participating in the following programs/diet in the last six months:

RENEW: Yes Currently □ Yes in the last six months □ No □

Dean Ornish-Spectrum: Yes Currently □ Yes in the last six months □ No □

Mediterranean Diet: Yes Currently □ Yes in the last six months □ No □

Weight Watchers: Yes Currently □ Yes in the last six months □ No □

Jenny Craig: Yes Currently □ Yes in the last six months □ No □

South Beach Diet: Yes Currently □ Yes in the last six months □ No □

The TLC Diet: Yes Currently □ Yes in the last six months □ No □

Other_ Specify;_____

42. Are you currently taking any of the following on a regular basis (i.e. MORE than one day per week, on average)?
If yes, for how many years?

Beta carotene:	θ Yes	for _____ years	θ	No
Vitamin E supplements (excluding multiple vitamins)	θ Yes	for _____ years	θ	No
Folic acid supplements (excluding multiple vitamins)	θ Yes	for _____years	θ	No
Multiple Vitamins	θ Yes	for _____years	θ	No
Anticoagulants (blood thinners) (e.g. Coumadin or Heparin)	θ Yes	for _____ years	θ	No

Immunosuppressive drugs (e.g. Prednisone)

θ Yes, currently
θ Yes, only in the past For ____months, ____yrs.
θ No, never

Estrogen replacement therapy (women only)

θ Yes for _____ years
θ No

Birth control pills (women only)

θ Yes, currently
for how long? _____
θ Yes, only in the past
θ No, never

43. How many drinks per day/week, on average, have you consumed, OVER THE LAST YEAR?
(1 drink = 1 glass, bottle or can of beer, one 4 oz. glass of wine, or one drink or shot of liquor)

θ None
θ Less than 3 drinks/month
θ One drink per week
θ 2-4 drinks per week
θ 5-6 drinks per week
θ One drink per day
θ 2-3 drinks per day
θ 4 or more drinks/day

44. How often do you engage in aerobic physical activity at least 30 minutes at a time (include brisk walking outdoors, swimming, aerobics, cycling, running, hiking, racquetball, etc.)?

θ rarely/never
θ less than once/week
θ once/week
θ 2-3 times/week
θ 4-6 times/week
θ daily

45. What is the highest level of education you completed?

θ Did not finish high school
θ Completed high school
θ Some college or trade school
θ Completed 4 year college degree
θ Graduate school or higher

46. Present household total income range:

θ	Under $18,999	(1)	θ	$60,000 – 79,999	(4)
θ	$19,000 - 39,999	(2)	θ	$80,000 – 99,999	(5)
θ	$40,000- 59,999	(3)	θ	Over $100,000	(6)

47. How do you describe your racial or ethnic group?

θ White, Non-Hispanic
θ Latino or Hispanic (Ancestry is Mexican, Cuban, Puerto Rican, Central American or South American)
θ Black or African-American
θ Asian or Pacific Islander (Ancestry is Chinese, Indo-Chinese, Korean, Japanese, Pacific Islander, or Vietnamese)
θ Native American or Alaskan Native
Other Specify: _____

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the appropriate blank. If you are unsure about how to answer a question, please give the best answer you can.

48. In general, would you say your health is:

θ Excellent
θ Very good
θ Good
θ Fair
θ Poor

The following items are about activities you might do during a typical day. Does your health now limit you these activities? If so, how much?

49. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
- θ Yes, limited a lot
- θ Yes, limited a little
- θ No, not limited at all

50. Lifting or carrying groceries?
- θ Yes, limited a lot
- θ Yes, limited a little
- θ No, not limited at all

51. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

A. Accomplished less than you would like?
- θ Yes
- θ No

B. Were limited in the kind of work or other activities?
- θ Yes
- θ No

52. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

A. Accomplished less than you would like?
- θ Yes
- θ No

B. Didn't do work or other activities as carefully as usual?
- θ Yes
- θ No

53. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?
- θ Not at all
- θ A little bit
- θ Moderately
- θ Quite a bit
- θ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:

54. Have you felt calm and peaceful?
- θ All of the time
- θ Most of the time
- θ A good bit of the time
- θ Some of the time
- θ A little of the time
- θ None of the time

55. Did you have a lot of energy?

θ All of the time
θ Most of the time
θ A good bit of the time
θ Some of the time
θ A little of the time
θ None of the time

56. Have you felt downhearted and blue?

θ All of the time
θ Most of the time
θ A good bit of the time
θ Some of the time
θ A little of the time
θ None of the time

57. In the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

θ All of the time
θ Most of the time
θ Some of the time
θ A little of the time
θ None of the above

58. Now, we would like to ask you a few general questions.

0	1	2	3	4
Never	Almost Never	Sometimes	Fairly Often	Very Often

In the last month, how often have you felt that you were unable to control the important things in your life? _____

In the last month, how often have you felt confident about your ability to handle your personal problems? _____

In the last month, how often have you felt that things were going your way? _____

In the last month, how often have you felt that difficulties were piling up so high that you could not overcome them? _____

HEALTH PRACTICES AND ATTITUDES

Take a look at the "Ladder of Health" below. Each sentence corresponds to a number. Pick **one** step on the ladder below which best fits where you are right now. **CHOOSE ONE NUMBER** . . .

As you think about your overall health, would you say:

	MOST HEALTHY
I am completely satisfied with my current health habits	10
I have made some healthy changes, but I need to keep working on it	9
I have begun to make some healthy changes	8
I plan to make healthy changes in the next 30 days	7
I plan to make healthy changes in the next 6 months	6
I often think about making healthy changes, but I have no plans	5
I sometimes think about making healthy changes, but I have no plans	4
I rarely think about making healthy changes and I have no plans	3
I do not think about the need to make healthy changes and I have no plans	2
I have decided not to make healthy changes	1
	LEAST HEALTHY

Now, look at each of the six ladders below one at a time. Read each heading, **choose one** number which best fits where you are with each health habit at this time.

	Reducing fat in my diet (e.g. taking skin off chicken; not adding margarine or butter to vegetables, etc.)	Increasing fruits/vegetables in my diet to at least 5 per day	Managing stress in my life (e.g., balancing work & family)
	MOST HEALTHY	MOST HEALTHY	MOST HEALTHY
I have made healthy changes and am completely satisfied with my current health habits.	10	10	10
I have made changes but I need to keep working on it	9	9	9
I have begun to make changes	8	8	8
I plan to make changes in the next 30 days	7	7	7
I plan to make changes in the next 6 months	6	6	6
I often think about making changes but I do not have any plans	5	5	5
I sometimes think about making changes, but I do not have any plans	4	4	4
I rarely think about changing and I do not have any plans	3	3	3
I do not think about the need to make healthy changes	2	2	2
I have decided not to make changes	1	1	1
	LEAST HEALTHY	LEAST HEALTHY	LEAST HEALTHY

	For Smokers Quitting Cigarette for Good	Increasing physical activity to at least 30 minutes of moderate exercise 5 days per week.	Achieving a desirable body weight
	MOST HEALTHY	MOST HEALTHY	MOST HEALTHY
I have made healthy changes and am completely satisfied with my current health habits.	10	10	10
I have made changes but I need to keep working on it	9	9	9
I have begun to make changes	8	8	8
I plan to make changes in the next 30 days	7	7	7
I plan to make changes in the next 6 months	6	6	6
I often think about making changes but I do not have any plans	5	5	5
I sometimes think about making changes, but I do not have any plans	4	4	4
I rarely think about changing and I do not have any plans	3	3	3
I do not think about the need to make healthy changes	2	2	2
I have decided not to make changes	1	1	1
	LEAST HEALTHY	LEAST HEALTHY	LEAST HEALTHY

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE