KEYS MEDICAL THERMOGRAPHY

Women's Full Body

Keys Medical Thermography · (305) 797-7603 · info@keysmt.com · form version 11, 2026-10-16

Name _____ Birth Date _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Phone Number (home) _____ Phone Number (cellular) _____ Phone Number (work) _____

Email _____ Physician's Name _____

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Head & Neck

Do you suffer with headaches? ☐ Yes ☐ No

If yes, ☐ once a month or less ☐ more than once a month

Do you have known allergies? ☐ Yes ☐ No

Food _____

Environmental _____

Do you have TMJ or does your jaw click? ☐ Yes ☐ No

Do you currently have a cold? ☐ Yes ☐ No

Are you being treated for a thyroid disorder? ☐ Yes ☐ No

Type _____

Do you have neck pain? ☐ Yes ☐ No

Do you have upper back pain? ☐ Yes ☐ No

Do you have a known history of carotid artery disease? ☐ Yes ☐ No

Do you have a family history of stroke? ☐ Yes ☐ No

Do you currently suffer with sinus problems? ☐ Yes ☐ No

Do you have history of dental problems? ☐ Yes ☐ No

☐ Root canals ☐ Gum disease ☐ Implants ☐ Non-replaced extractions

☐ Dentures

Have you had dental cleaning in the past 7 days? ☐ Yes ☐ No

Have you been diagnosed with elevated cholesterol? ☐ Yes ☐ No

Do you have any special concerns or are there any details related to the information above?

Breast

Is there a specific reason or concern for this breast exam?

Have you recently had any of these breast symptoms? (Mark only if "yes") ☐ Yes ☐ No

- Pain/Tenderness ☐ LT ☐ RT
- Lumps ☐ LT ☐ RT
- Change in breast size ☐ LT ☐ RT
- Areas of skin changes thickening or dimpling ☐ LT ☐ RT
- Excretions or changes of the nipple ☐ LT ☐ RT

Are any of the above symptoms cycle related? ☐ Yes ☐ No

Are you still having your periods? ☐ Yes ☐ No

If yes, date of last period _____

Have you had a surgical hysterectomy? ☐ Yes ☐ No

If yes, date _____

☐ Complete ☐ Partial

Reason for hysterectomy: ☐ Excess bleeding ☐ Endometriosis ☐ Fibroid cysts ☐ Cancer ☐ Other

Has anyone in your family ever been treated for breast cancer? ☐ Yes ☐ No

If yes, note age and survival ☐ Mother ☐ Grandmother ☐ Sister ☐ Daughter

Age diagnosed _____

Result of Treatment _____

Have you ever been diagnosed with breast cancer? ☐ Yes ☐ No

If yes, date: Month _____ Year _____

Cancer type ☐ Local ☐ Metastatic ☐ Lymph node involvement

Left breast ☐ Inner ☐ Outer ☐ Nipple

Right breast ☐ Inner ☐ Outer ☐ Nipple

Treatment ☐ Surgery ☐ Chemo ☐ Radiation ☐ None

If surgery; ☐ Mastectomy ☐ Lumpectomy

Have you ever been diagnosed with any other breast disease? ☐ Yes ☐ No

If yes, ☐ Cysts/fibrocystic ☐ Fibro Adenoma ☐ Mastitis/inflammatory breast disease

Have you had any cosmetic breast surgery or implants? ☐ Yes ☐ No

If yes, date _____

☐ Silicone ☐ Saline

Experience: ☐ Problems ☐ No problems

Have you ever had any biopsies or any other surgeries to your breasts ☐ Yes ☐ No

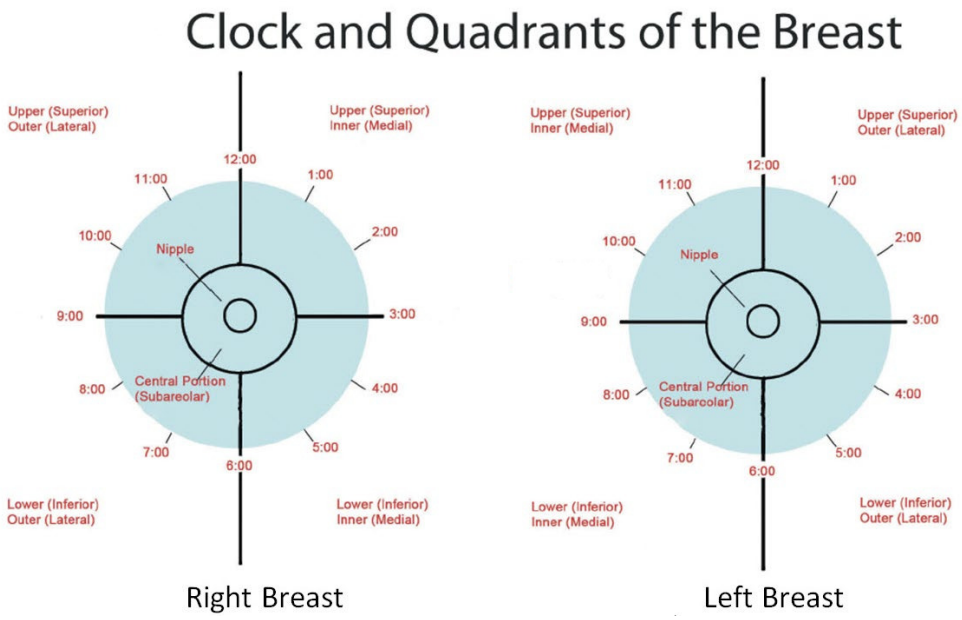
If yes, date _____

Left breast ☐ Inner ☐ Outer ☐ Nipple

Right breast ☐ Inner ☐ Outer ☐ Nipple

Results ☐ Negative ☐ Positive ☐ Calcifications

Mark on the following graph to indicate location of pain, surgery or lumps:



Have you ever taken contraceptive pills for more than one year? ☐ Yes ☐ No

If yes, ☐ Currently ☐ Less than 5 years ☐ More than 5 years

Have you had pharmaceutical hormone replacement therapy (HRT)? ☐ Yes ☐ No

If yes, ☐ Currently ☐ Less than 5 years ☐ More than 5 years

Do you have an annual physical examination by a doctor? ☐ Yes ☐ No

Do you perform a monthly breast self-exam? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Have you ever been diagnosed with diabetes? ☐ Yes ☐ No

Total mammograms _____

Date of last mammogram _____

Were you re-called? ☐ Yes ☐ No

Your age at your first mammogram: _____

Number of full term pregnancies: _____

Have you had breast ultrasound? ☐ Yes ☐ No

> *If yes…Date:* _____
>
> ☐ Left ☐ Right
>
> Results: ☐ Negative ☐ Positive

Have you had breast MRI? ☐ Yes ☐ No

> *If yes…Date:* _____
>
> ☐ Left ☐ Right
>
> Results: ☐ Negative ☐ Positive

Chest, Heart & Lungs

Have you been diagnosed with:

Heart disease? ☐ Yes ☐ No

Lung disease? ☐ Yes ☐ No

Upper spine disorders? ☐ Yes ☐ No

Do you suffer with upper back pain? ☐ Yes ☐ No

Do you suffer with chest pain? ☐ Yes ☐ No

Have you been diagnosed with scoliosis? ☐ Yes ☐ No

Have you ever had surgery to your:

Heart? ☐ Yes ☐ No

Lungs? ☐ Yes ☐ No

Mid to upper back? ☐ Yes ☐ No

Do you have asthma or shortness of breath? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No

Have you smoked in the past 5 years? ☐ Yes ☐ No

Do you suffer with shoulder pain? ☐ Yes ☐ No

If yes, mark below

Abdomen & Lower Back

Do you suffer from acid reflux or other digestive problems? ☐ Yes ☐ No

Do you suffer pain in the:

Stomach?	☐ Yes	☐ No
Below R Breast?	☐ Yes	☐ No
Below L Breast?	☐ Yes	☐ No
Abdomen?	☐ Yes	☐ No
Lower Back?	☐ Yes	☐ No
Pelvic Region?	☐ Yes	☐ No

Have you had surgery or disease in the:

Stomach?	☐ Yes	☐ No
Spleen (Upper Left)?	☐ Yes	☐ No
Liver (Upper Right)?	☐ Yes	☐ No
Kidneys?	☐ Yes	☐ No
Intestines?	☐ Yes	☐ No
Abdomen?	☐ Yes	☐ No
Lower Back?	☐ Yes	☐ No
Pelvic Region?	☐ Yes	☐ No

Have you consumed alcohol in the past 24 hours? ☐ Yes ☐ No

Legs & Feet

Check only if "Yes"

Do you suffer pain in the:

Leg?	☐ LT	☐ RT
Sciatica	☐ LT	☐ RT
Buttocks/Hip?	☐ LT	☐ RT
Knees?	☐ LT	☐ RT
Ankles?	☐ LT	☐ RT
Feet?	☐ LT	☐ RT

Have you had Surgery to:

Leg?	☐ LT	☐ RT
Sciatica?	☐ LT	☐ RT
Buttocks/Hip?	☐ LT	☐ RT
Knees?	☐ LT	☐ RT
Ankles?	☐ LT	☐ RT
Feet?	☐ LT	☐ RT

Arms & Hands

(Check only if "yes")

Do you suffer with pain in the:

Shoulder?	☐ LT	☐ RT
Elbow?	☐ LT	☐ RT
Arm?	☐ LT	☐ RT
Hands?	☐ LT	☐ RT

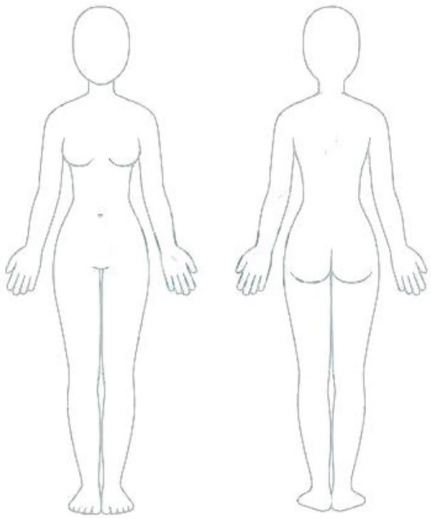
Have you had surgery to:

Shoulder?	☐ LT	☐ RT
Elbow?	☐ LT	☐ RT
Arm?	☐ LT	☐ RT
Hands?	☐ LT	☐ RT

Do you have any special concerns or are there any details related to the information above?

Areas of Pain

Mark on the following graph to indicate location of pain, surgery or injury:



Areas of Pain

Do you have any special concerns or are there any details related to the information above?

Client/Patient Disclosure

- Thermography is non-contact, private, and non-invasive.
- It measures skin temperature patterns and provides information other tests cannot.
- Thermography does not replace mammography, ultrasound, MRI, or any other imaging.
- All breast tests are complementary; best practice is a multimodal approach.
- Thermography does not diagnose or treat any condition.
- An "Elevated Level of Concern" does not indicate suspicion for a specific disease.
- Any concerning finding will include a recommendation for further clinical evaluation.
- If you notice a lump or breast change at any time, contact your doctor promptly.

For clients with a prior cancer diagnosis:

- Thermography evaluates temperature patterns only.
- It does not monitor cancer or disease progression.
- Ongoing follow-up and additional testing with your physician is strongly advised.

About your Thermographer:

- Your thermographer may not be a licensed medical professional.
- Your thermographer cannot interpret images, diagnose, prescribe, or give medical advice.
- Your thermographer may collect health history and provide general breast-health education.

By signing below, I confirm that I have read and understand this disclosure and consent to the thermal examination.

Signature

Date