THERMOGRAPHY CLINIC INC.

Cranial / Dental Health History

Name: ____Date of Birth____________
mm/dd/yyyy

Address: ____

City: ____________________ State/Province: _____________ ZIP/Postal Code _____________

Telephone: Home __________________ Work _________________Cell __________________

E-mail: ____

Occupation: _________________________ Referred By: ______________________________

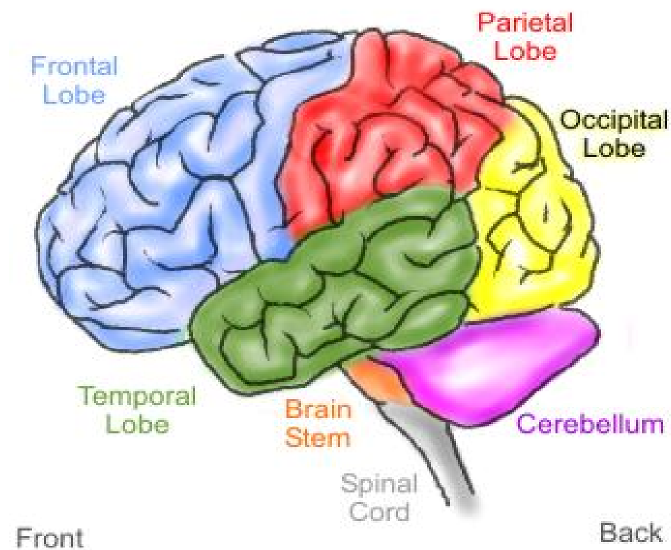
What is the primary reason for this examination? ____

Are you experiencing any of the following symptoms?

❒ Y ❒ N Headaches
Is it ❒ Dull ❒ Sharp ❒ Cluster ❒ Sinus ❒ Other

Location ❒ R ❒ L

❒ Frontal Lobe ❒ Parietal Lobe
❒ Temporal Lobe ❒ Occipital Lobe (rearmost part of scull)



❐ Y ❐ N Nasal Condition ❐ R ❐ L

❐ Y ❐ N Allergies
❐ Seasonal ❐ Hay Fever ❐ Food ❐ Dust ❐ Mold ❐ Pets ❐ Unknown

❐ Y ❐ N Have you ever been diagnosed with Cerebral Circulatory Problems?
Please explain: ______________________________

❐ Y ❐ N Have you been Diagnosed with Thyroid condition?
❐ Hypo ❐ Hyper ❐ Hashimoto's ❐ Grave's ❐ Goiter ❐ Cancer ❐ Unknown

❐ Y ❐ N Other Conditions ______________________________

❐ Y ❐ N Do you have a specific dental problem?
Describe: ______________________________

❐ Y ❐ N Do you have dental examinations on a routine basis? Date of last visit: ____________
mm/dd/yyyy

Please indicate if you have any of the following conditions?

❐ Y ❐ N Have you ever been diagnosed with TMJ? Temporomandibular Joint Disorder

❐ Y ❐ N Root Canal Treatments ❐ Upper Left ❐ Upper Right ❐ Lower Left ❐ Lower Right

❐ Y ❐ N Do your gums ever bleed?

❐ Y ❐ N Do you clench or grind your teeth

❐ Y ❐ N Does your jaw hurt or click? ❐ R ❐ L

❐ Y ❐ N Do you have any difficulty chewing?

❐ Y ❐ N Do you think you have active decay or gum disease

Please note any other concerns/issues you may have: ______________________________

____

General Health Information

❐ Y ❐ N Do you have any medical complaints or conditions? Please explain ____________
____

❐ Y ❐ N Are you currently taking any medications? Please list ____________
____