

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? _____

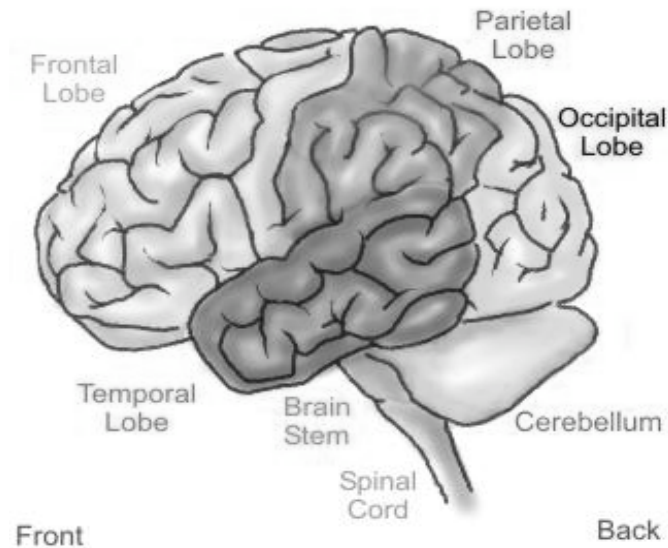
Are you experiencing any of the following symptoms?

Y N Headaches
Is it Dull Sharp Cluster Sinus Other

Location R L

Frontal Lobe Parietal Lobe
 Temporal Lobe Occipital Lobe (rearmost part of skull)

Regions of the Human Brain



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 _____
