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THERMOGRAPHY CLINIC INC.

Cranial Dental History Form

Name: ______________________________ Date of Birth: ____________
mm/dd/yyyy

Address: ______________________________

City: ______________ State: ____________ ZIP Code: ____________

Telephone: (H) ____________ (W) ____________ (C) ____________

E-mail: ______________________________

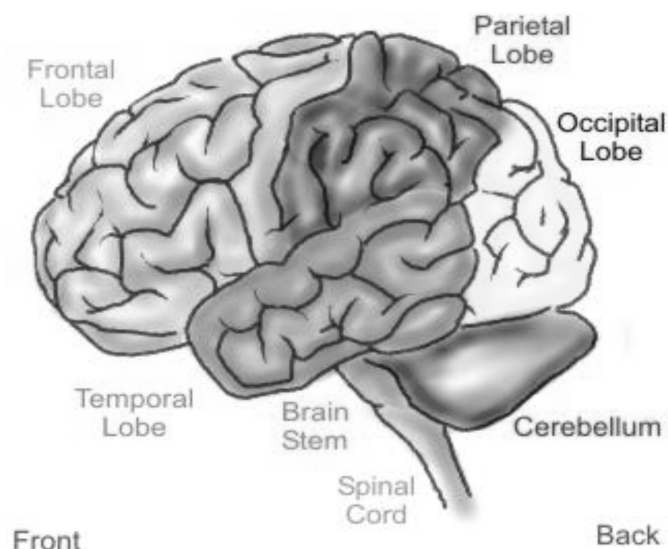
Occupation: ______________ Referred By: ______________

What is the primary reason for this examination? ______________

Are you experiencing any of the following symptoms?

❒ Y ❒ N Headaches
If yes, are they ❒ Dull ❒ Sharp ❒ Cluster ❒ Sinus ❒ Other

Location ❒ R ❒ L ❒ Frontal Lobe ❒ Parietal Lobe
❒ Temporal Lobe ❒ Occipital Lobe (rearmost part of skull)



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❒ 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 Do your jaws 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?

Cranial Dental History Form

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:

____

____