Hindsight Thermography
A different perspective.

Cranial / Dental Health History

Name: _____Date of Birth_____

Address: _____

City: _____ Province: _____ Postal Code _____

Telephone: Home _____ Work _____Cell _____

E-mail: _____

Occupation: _____ Referred By: _____

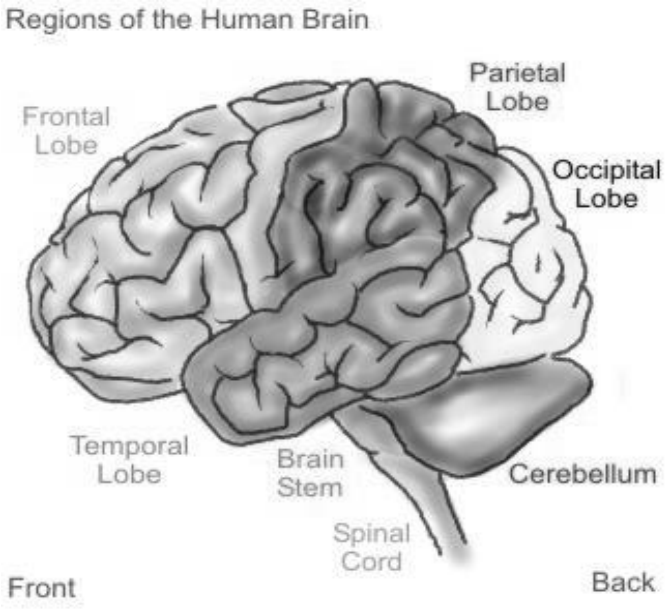
What is the primary reason for this examination? _____

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: _____

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 clicks? ❒ 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 _____
_____