

VANCOUVER
442 - 23rd Street W,
North Vancouver, BC V7M 2B7
t: (778) 340-1947

CALGARY
#301, 812 14th Ave,
SW Calgary, AB T2R 0N6
t: (403) 686-2113



Suzanne Sutherland
**THERMOGRAPHIC
• IMAGING •**

CRANIAL, DENTAL & THYROID HEALTH HISTORY

Name: _____ Age: _____ Date of Birth: _____

Street: _____ City: _____

Province: _____ Postal Code: _____

Home Tel: _____ Work Tel: _____ Cell: _____

E-mail: _____ Occupation: _____

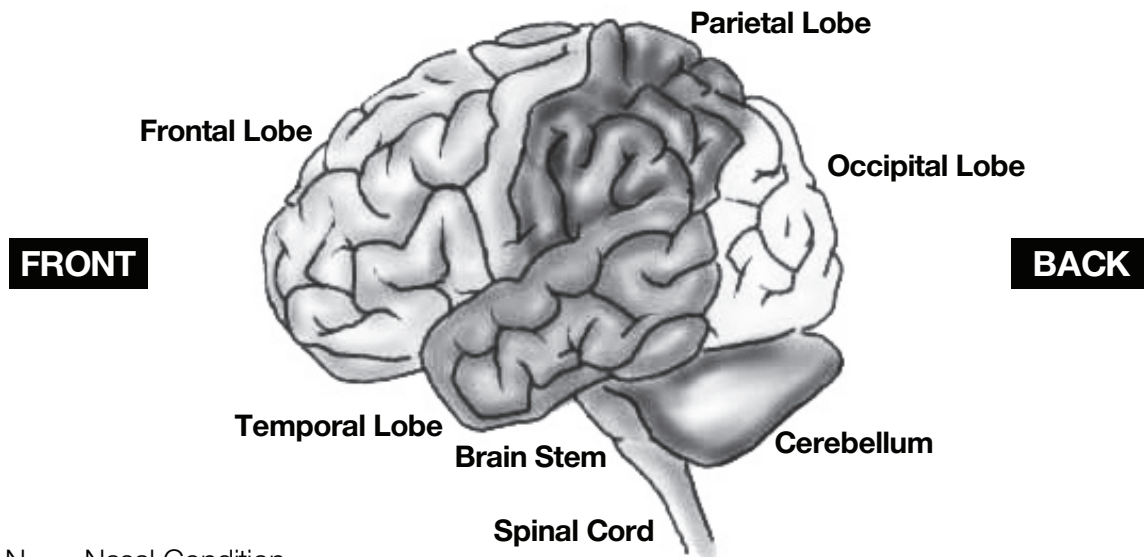
Referred By: _____

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: _____

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Y N Have you been diagnosed with a Thyroid Condition?
 Hypo Hyper Hashimoto's Grave's Goiter Cancer Unknown

Y N Have you ever been diagnosed with Other Conditions?
Please explain: _____

Y N Do you have a specific Dental Problem?
Please explain: _____

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: _____

