VANCOUVER
North Vancouver
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: _____

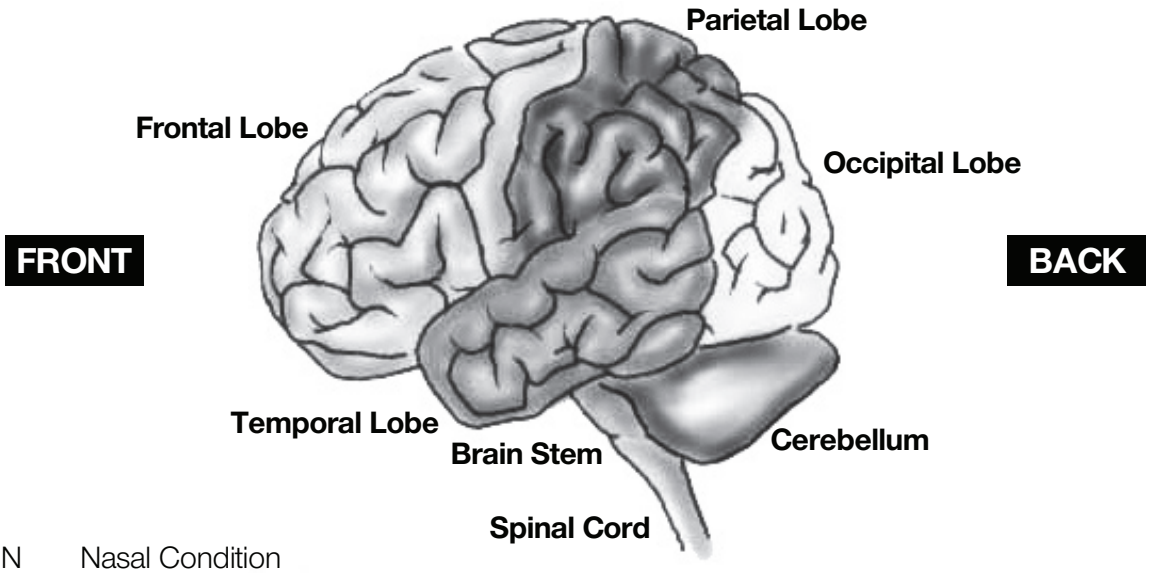
Referred By: _____

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 scull)

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: _____