

BOSTON THERMOGRAPHY CENTER, INC.

BostonThermography.com

617-389-3828

Cranial / Dental Health History

Name: _____ Date of Birth _____

Address: _____

City: _____ State: _____ ZIP Code _____

Telephone: Home _____ Work _____ Cell _____

E-mail: _____

Occupation: _____ Referred By: _____

What is the primary reason for this examination? _____

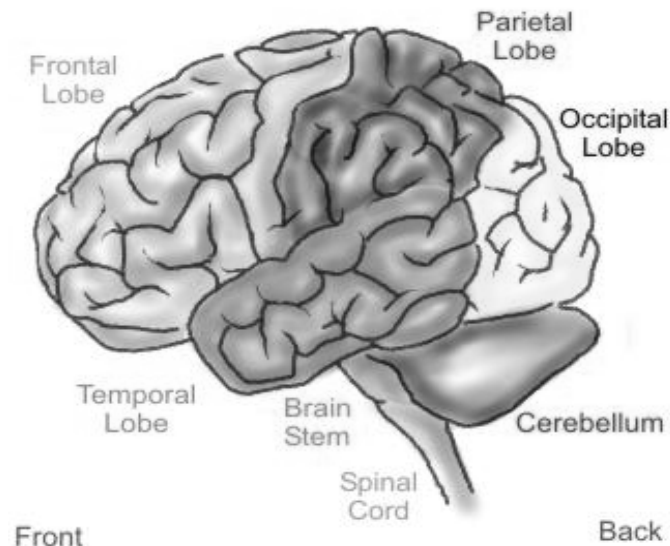
Are you experiencing any of the following symptoms?

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: _____

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 _____