Oral Function SPECIALTIES

Connecting oral health and wellness through a lifetime

Name: _____ Nick Name: _____ DOB: _____

Date of last medical exam:_____ Date of last dental exam: _____

Please give a reason for your visit today:_____

_____

Are you now under the care of a physician? _____ yes _____ no

If yes, what condition is being treated? _____

Has there been any change in your health in the past year? _____

If yes, what change has occurred? _____

Are you taking any medicines, drugs or nutritional supplements now? _____ yes _____ no

If yes, please list: _____

Are you allergic to any medications, foods and/or drugs? _____ yes _____no

If yes, please list: _____

Are you allergic to latex? _____ yes _____ no

Do you smoke or use tobacco? _____yes _____no

Have you had your tonsils and/or adenoids removed? _____yes _____no

Do you have any allergies that make your nose stuffed on a regular basis? _____yes _____no

Do you have a tendency towards colds, strep, sore throats, headaches or ear infections? _____yes _____no

If yes, please list which ones and frequency: _____

Has there ever been any injury to the head, neck, back or pelvic region? _____yes _____no

If yes, please explain: _____

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Do you have any jaw pain or popping sounds? _____yes _____no

Do you clench or grind your teeth? _____yes _____no

Have you ever been treated for a TMJ problem? _____yes _____no

Have you ever had orthodontic treatment? _____yes _____no

Have you ever had oral surgery? _____yes _____no

Do you bite your cheeks, tongue or lips regularly? _____yes _____no

Do you breathe through your mouth during the day or at night time? _____yes _____no

Do you snore or have sleep apnea? _____yes _____no

Do you hold foreign objects with your teeth? (pencils, clothes, fingernails) _____yes _____no

Have you ever sucked your thumb or fingers? _____yes _____no

Have you ever had speech therapy? _____yes _____no

Have you ever been diagnosed with:

_____ Allergies/Hay Fever/Asthma

_____ Neurological Disorders

_____ ADD/ADHD

_____ TMJ Pain

_____ Headaches

_____ Swallowing issues

_____ GERD/Reflux

_____ Dental/Orthodontic work

_____ Frequent Strep infections

_____ Tinnitus

Do you have any other physical condition, disease, problem or concern not addressed above?
_____ yes _____no

If yes, please list: _____

_____

_____

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I understand the above information is necessary to provide me with an orofacial myofunctional program in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my therapist of any change in my health or medication.

Patient/parent signature: _____ Date: _____

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