Nebraska Myofunctional Specialties, LLC

MEDICAL AND DENTAL HISTORY

for

Name:_____

Birth Date:_____

Although Myofunctional Therapists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the therapy you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ___Yes ___No If yes, please explain:_____
_____

Have you ever had a serious head or neck injury? ___Yes ___No If yes, please explain:_____
_____

Are you taking any medication, vitamins or herbs? ___Yes ___No If yes, please list: _____
_____

Past Medical history

Preventive Care _____ _
Major Events: _____
Ongoing Medical Problems: _____
Allergies
___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex
___Other_____
Other allergies
Food_____
Environmental _____ ____% of time Testing? _____ Shots?_____
Airway concern _____Lips parted slightly at rest _____Congestion: Occasionally/Often/ Always
___Nasal sprays ____Inhaler, _____ Pushes nose_____
Dark circles under eyes _____Tonsillectomy/Adenoidectomy?_____
Sinus /Sore Throat/Colds: Frequency_____
Ears: ____ache _____Buzzing/Ringing Frequency _____
Headaches: Where:_____ Frequency:_____

Developmental History

Birth _____ Complications_____
Infant feeding method/how long _____
Type of nipple used on bottle/pacifier_____
How long for pacifier/thumb sucking _____
Use of sippy cup/how long _____
Crawl/Walk/Talk Milestones _____
Prior speech therapy _____no _____yes With whom? _____
How long? _____ Describe _____

Social History

Smoking _____ Alcohol _____ Controlled substances _____
Activities involved with_____
Musical Instruments played _____
Comments:

Pain Symptoms

_____Right /Left jaw ___Nasal ___ Sinus ___Forehead _____Right /Left Temples
_____Behind Eyes _____Mask _____Top _____Back of head _____Neck _____Shoulders
_____ Right/Left Arm _____Right/Left Hand _____
Low /Mid /Upper back ____Right /Left Leg ____ Right/Left Foot
Frequency:_____

_____Teeth grinding _____ Jaw clenching Night or Day? _____
Do you wear a mouth guard? _____Pain symptoms//frequency _____
Past treatment sought for pain?

Nutrition History

Food likes _____
Food Dislikes _____

Pop ____x/week Candy ____x/week High sweet intake? __ yes __no
Finicky eater? ____yes _____no
Limited Fruits/vegetables? _____
___Gas ____Burping _____Hiccups _____/Stomach aches
___Difficulty taking pills ___Effort ___uses liquid or crushes pills
Comments:

Orthodontic History

Orthodontist name:_____ ____
Current appliance:_____ Upper/lower Braces _____
Palatal Expansion _____Head/Neck gear _____Elastics ____Functional - Type: _____
Appliances: _____Retainers _____Positioners _____Orthotic _____Relapse _____Years Rx.
Comments:

Concerns: ___Thumb/Finger Habit ___Tongue Thrust ___Speech concern ___TMJ concern ___Relapse ___In Braces
Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Nebraska Myofunctional Specialties of any changes in medical and dental status.

Signature of Patient, Parent, or Guardian_____Date_____