NEBRASKA
MYOFUNCTIONAL SPECIALTIES

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BOARD CERTIFIED OROFACIAL MYOLOGIST
LICENSE #613 TIN 26-3623727 NPI 1639505092

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: Please list year

_____

_____

Ongoing Medical Problems:

_____

_____

_____

Allergies

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ____Other (please list)

_____

Food Allergies: _____

Environmental Allergies _____

Have you had Testing? _____With whom? _____Shots?_____

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

Area: _____ Frequency: _____
Jaw clenching or grinding? Night or Day? _____Do you wear a mouth guard? _____
Past treatment sought for pain?

Nutrition History: Please list specific foods

Food likes _____

Food Dislikes _____

Pop ____x/week Candy ____x/week High sweet intake? __ yes __no
Finicky eater? ____yes _____no
Limited Fruits/vegetables? _____
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_____