Oral Myofunctional Case History Background Information

Date: _______________

Name: ____ **DOB:**_________________ **Age:**____________

Your name and relationship to the child: ____

Describe your concerns regarding your child:

Was this evaluation recommended by another professional? ________ Yes ________ No

If yes, by who, and what concerns were shared with you?

Dentist's Name: ____Last Dental Exam: __________________

Has the patient been evaluated by an orthodontist? ________ Yes ________ No

- If "yes", by who? ____ Last Exam: _______________________

If the patient has had orthodontic treatment, what kind and for how long?

Oral Habits

- Does the patient have a history of a thumb or finger sucking habit? ________ Yes ________ No
    - If yes, is the habit discontinued? ________ Yes ________ No
    - At what age was the sucking habit discontinued? _______________________
- Did the patient use a pacifier? ________ Yes ________ No
    - If yes, until what age? _______________________
- Does the patient ever suck his/her tongue/lips? ________ Yes ________ No
    - Other objects? ________ Yes ________ No
- Does the patient have a fingernail biting habit? ________ Yes ________ No
    - If so, what age did it begin? _______________________

Speech

Do you have any speech concerns? ________ Yes ________ No

Has the patient had speech therapy? ________ Yes ________ No

- If so, how long? ______________________
- What agencies have provided speech therapy? ____
- Does your child receive speech therapy services through the school district? __________ Yes __________ No
  - If yes, how often? ______________________
- Name of child's therapist: _____________________________________Phone number: _____________________

Sleep

Does the patient snore while sleeping? _______ Yes _______ No

- If so, is the snoring loud? _______ Yes _______ No
  - Occasional? _________ Frequent ? _____________

Does the patient have a problem with bedwetting? ________ Yes ________ No

Does the patient have unusual sleeping positions? ________ Yes ________ No

- If so, please describe:

Does the patient have difficulty awakening in the morning and/or appear disoriented or groggy? ______ Yes ______ No

Does the patient appear sluggish or groggy during the day? ________ Yes ________ No

Is the patient frequently cranky/irritable? ________ Yes ________ No

Medical

Prenatal History:

Were there any illnesses, injuries, bleeding or any other difficulties before birth? ________ Yes ________ No

Was the patient born prematurely or significantly past the due date? ________ Yes ________ No

- If yes, please give weeks and weight? ____

Were there any complications with labor or delivery? Yes________ Yes ________ No

- If yes, please describe.

Feeding:

Was the child breast- or bottle-fed? ______________________

Were there any feeding difficulties? ________ Yes ________ No

- If yes, please describe.

Health History:

Does the child experience frequent ear infections or fluid in the ears? ________ Yes ________ No

Approximately how many or how often? ______________________

Has the child ever had PE tubes? ________ Yes ________ No

- If yes, are they still in? ________ Yes ________ No
- In what ear(s)? _____Right____ Left

Has the child ever had their hearing tested? ________ Yes ________ No

- If yes, when and what were the results.

Does the child have any allergies, sinusitis, or frequent congestion? ________ Yes ________ No

- If yes, please describe

Has the child been diagnosed as having a deviated septum? ________ Yes ________ No

Has the child had tonsillitis? ________ Yes ________ No

- If so, how frequent? ______________________
  - When was the last occurrence? ______________________

Has the child had tonsils removed? ________ Yes ________ No

- If so, when?

Has the child had adenoids removed? ________ Yes ________ No

- If so, when?

Has the child had strep throat? ________ Yes ________ No

- If so, how frequent? __________________
  - When was the last occurrence? __________________

Does the child complain of frequent headaches? ________ Yes ________ No

Does the child take any medications? ________ Yes ________ No

- If so, please give details.

Does the child have lips parted frequently? ________ Yes ________ No