Cherry Creek
OROFACIAL MYOLOGY

CHERRY CREEK OROFACIAL MYOLOGY

Patient Medical/Dental History Form

Name: _____ Date of Birth: _____ Age: _____

Sex: M F

Date of last medical exam: _____ Physician: _____

Date of last dental exam: _____ General health: excellent good fair poor

Please give a reason for your visit today: _____

_____

Are you now under the care of a physician:..... Yes No

If yes, what is the condition being treated _____

Has there been any change in your general health within the past year?..... Yes No

Have you been hospitalized or had a serious illness or accident within the past five (5) years? Yes No

If yes, what change has occurred? _____

Have you ever had any major operations?..... Yes No

If yes, please list type and date _____

Are you taking any medicines, drugs, or nutritional supplements now?..... Yes No

If yes, please list _____

Are you allergic (or had any adverse reactions) to any medications, anesthetics, foods, and/or drugs?..... Yes No

If yes, please list _____

Do you have any allergy to latex?..... Yes No

Do you smoke or chew tobacco?..... Yes No

Do you drink alcohol?..... Yes No

If yes, how often and how much? _____

Have you had your tonsils or adenoids removed?..... Yes No

If yes, at what age? _____

Do you have a tendency towards colds, Strep, sore throats, ear infections, headaches?..... Yes No

If yes, please list which ones and frequency _____

Do you have any jaw pain or popping sounds?..... Yes No

Has there ever been any injury to the head, neck, back or pelvic region?..... Yes No

If yes, please explain _____

Do you breathe through your mouth during the day or at night time?..... Yes No

Do you snore?..... Yes No

Have you ever sucked your thumb or fingers?..... Yes No

If yes, until what age? _____

Have you ever had speech therapy?..... Yes No

If yes, for which letters or sounds? _____

Do you ever grind or clench your teeth?..... Yes No

Have you ever been treated for a TMJ problem?..... Yes No

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Patient Medical/Dental History Form (con't)

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
Have you ever had periodontal surgery?..... Yes No
Do you hold foreign objects with your teeth? (pencils, pipe, clothes, fingernails) ..... Yes No
How often do you brush your teeth? _____ How often do you floss? _____

HAVE YOU EVER BEEN TREATED FOR OR ADVISED THAT YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK:

- ☐ Heart Surgery
- ☐ Heart Disorder
- ☐ Myocardial Infarction
- ☐ Chest Pain (Angina Pectoris)
- ☐ Shortness of Breath
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ High/Low Blood Pressure
- ☐ Artificial Heart Valve
- ☐ Allergies
- ☐ Hay Fever
- ☐ Cancer
- ☐ Hepatitis
- ☐ Venereal Disease
- ☐ Herpes
- ☐ A.I.D.S.
- ☐ HIV Positive
- ☐ Cold Sores/Fever Blisters
- ☐ Blood Disorders
- ☐ Blood Transfusions
- ☐ Anemia
- ☐ Hemophilia
- ☐ Neurological Disorders
- ☐ Epilepsy or Seizures
- ☐ ADD/ADHD
- ☐ Stroke
- ☐ Bell's Palsy
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Artificial Joint
- ☐ Kidney Troubles
- ☐ Psychological Care
- ☐ Alzheimer's Disease
- ☐ TMJ Pain
- ☐ Headaches
- ☐ Tinnitus
- ☐ Drug Dependency

Do you have any other physical condition, disease, problem or concern not listed above? ..... Yes No

If yes, please list _____

_____

_____

I understand the above information is necessary to provide me with Orofacial Myofunctional Therapy 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 the therapist of any change in my health or medication.

PATIENT / PARENT / GUARDIAN SIGNATURE _____

DATE _____