Patient Name: _____

Age/DOB: _____

Date of Exam: _____

Patient History:

As a baby were you breastfed or bottle-fed? ☐ Breastfed ☐ Bottle-fed ☐ Unknown

As a child, did you have a history of ear infections? ☐ Yes ☐ No ☐ Unknown

Did you have a complicated birth, C-section birth, or premature birth? Trouble latching or feeding?

Notes:

Have you ever had a finger or thumb sucking habit? ☐ Yes ☐ No

If yes, how long? _____

As an infant, child and/or adult, did you have any allergies? Yes ☐ ☐ No

What are you allergic to? _____

How do you manage/treat symptoms? _____

Do you have a history of other breathing issues:

☐ Asthma	☐ Turbinate Reduction	☐ Airway Surgeries
☐ Chronic Nasal Congestion	☐ Sinus Infections	☐ COPD
☐ Deviated Septum	☐ Nasal Polyps	☐ Tuberculosis

Notes:

As an infant, child and/or adult, have you had issues with digestion, bloating or gassiness, or acid reflux?

Notes:

Speech: _____

Have you ever been in speech therapy? ☐ Yes ☐ No How long / what sounds?

Do parents notice any problems with clarity, mumbling, voice projection, lack of facial movement?

Notes:

Oral Posture:

Do you naturally breathe through your mouth or nose? ☐ Nose ☐ Mouth ☐ Both

Do you sleep with your mouth open or closed? ☐ Open ☐ Closed ☐ Both

Do you often feel like your nose is blocked or congested? ☐ Yes ☐ No

Where does the tip of your tongue rest in your mouth? _____

Notes and observations:

Eating, Drinking, Swallowing:

Do you have a hyperactive gag reflex? ☐ Yes ☐ No

Is it difficult for you to swallow pills? ☐ Yes ☐ No

Do you chew with your mouth open? ☐ Yes ☐ No

Do you feel like you need water to help wash down food as you eat? ☐ Yes ☐ No

Do you have trouble swallowing or a history of choking? ☐ Yes ☐ No

Other/Notes:

Dental /Orthodontic:

Do you have a history of tooth decay, gum disease, recession, or gum grafts? Notes:

Have you had orthodontic treatment in the past? ☐ Yes ☐ No

If not, have you been evaluated? Did you have premolars extracted?

Have you noticed that your teeth have shifted or changed (orthodontic relapse)? ☐ Yes ☐ No

Did you have: ☐ expander ☐ tongue crib/rake ☐ head gear ☐ elastics

Notes:

Head, Neck, TMJ:

Have you ever used an occlusal guard/night guard? ☐ Yes ☐ No

Headache Frequency:

Scale of Pain from 0-10 (0=No pain/10=The worst pain):

TMJ or Facial Pain: ☐ Daily ☐ Weekly ☐ Monthly ☐ Sometimes ☐ Never

Scale of Pain from 0-10 (0- No pain/10= The worse pain):

How do you manage or treat your pain? Pain description, location, notes:

Posture Characteristics: ☐ WNL ☐ Rolled shoulders ☐ Forward head

What do you think of your posture?_____

_____

Facial Development:

☐ Low tone appearance ☐ long/narrow face ☐ dimpled chin ☐ vertical angle or small mandible

- ☐ gummy smile Notes:

Sleep:

Do you snore? ☐ Yes ☐ No ☐ Unknown

Average hours of sleep each night?_____ Do you wake up feeling refreshed? _____

Are you tired during the day or do you feel chronically run down or fatigued? ☐ Yes ☐ No

Have you been tested for sleep apnea? ☐ Yes ☐ No

If yes, when and what was your diagnosis? AHI, RDI, oxygen desaturation:

Do you have a CPAP or dental sleep appliance?

☐ CPAP ☐ Dental appliance Do you wear it? ☐ Yes ☐ No

Notes: