Patient Name:

DOB:

MRN#

UW Health uwhealth.org
(University of Wisconsin Hospitals and Clinics Authority)

OROFACIAL MYOFUNCTIONAL HISTORY – CHILD

**** Please bring completed form to evaluation. Thank you! ****

Child's Name: _____ Address: _____ Phone: _____
School: _____ Grade: _____ Birth Date: _____
Date of Evaluation: _____ Insurance: _____

Name of Dentist: _____ Address: _____
Orthodontist: _____ Address: _____
Pediatrician: _____ Address: _____
Referred By: _____ Address: _____
Was Child Breast-Fed? _____ Until What Age? _____
Was Child Bottle-Fed? _____ Age Started? _____ Until What Age? _____
Did Child Suck Thumb or Fingers? _____ Until What Age? _____
Used Pacifier? _____ Until What Age? _____
Tongue Sucking or Tongue Chewing? _____
Nail or Cuticle Biter? _____
Chews on Pencils, Knuckles, Blankets? _____
Licks Lips Excessively? _____
Lip or Cheek Biting? _____
Is Child a Noisy Eater? _____
Any difficulty swallowing pills?_____
Does Child Play a Musical Instrument That Involves the Mouth? _____
Any Family Member With a Tongue Thrust? _____

How is Child's General Health? _____
On Any Medications? _____
Is Child a Mouth Breather? _____ During Day? _____ Night? _____
Any Temporomandibular Joint (TMJ) Problems? _____
Any History of Frequent Middle Ear Infections? _____
Have Tonsils & Adenoids Been Checked Recently? _____ By Whom? _____
If So, What Was Doctor's Opinion? _____
Does Child Have Allergies? _____ If So, How Treated? _____
Sinus Problems? _____ If So, How Treated? _____
Asthma? _____ If So, How Treated? _____
Chronic Upper Respiratory Infections/Colds? _____
Has Child Ever Had Tongue Thrust Therapy? _____ If So, Was Therapy Successful? _____

Did Child Ever Have Speech Problem? _____ Describe: _____
Has Child Ever Had Speech Therapy? ____ For What Problem and For How Long? _____

Was Speech Therapy Successful? _____

Has Child Had Orthodontic Work in the Past? _____
Is Palate Expansion Being Discussed? _____
If Currently in Braces, When Were They Applied? _____
What Happened to Dentition When Braces Were Removed? _____
Does Child Wear a Retainer? _____ For How Long? _____
Early Loss of Baby Teeth? _____ Permanent Teeth Slow to Come In? _____
Additional Information: _____