Adult OMD Questionnaire

Date: _____

Personal Information:

Name: _____

Birth Date: _____ Age: _____ Gender: M ____ F____

Cell Phone: _____ Home Phone: _____

Email:_____

Address/City: _____

Referred By: _____

Interested in appointment reminders? Text _____ Email_____

Dental Information & History:

Dentist's Name: _____ Phone: _____

Have you ever had any teeth extracted? Yes No

Have you had a palate expansion? Yes No Date of Expansion: _____

Are braces being considered? Yes No

Do you wear a dental appliance? Yes No

Healthcare Provider Information:

Name: _____ Phone: _____

Speech History:

Have you ever had speech therapy? Yes No

Did your speech improve with therapy? Yes No

If not, what concerns do you have? _____

Medical History:

Any history of the following (please circle):

Frequent colds Snoring Seasonal allergies

Head or Neck Surgeries Sleep Apnea

Tonsillectomy/Adenoidectomy, Date/Results: _____

Allergies/Intolerances to Food, Describe: _____

GERD/Acid Reflux, Treatment: _____

Eating and Drinking Habits:

I am a (circle all that apply):

Slow Eater Typical Eater Fast Eater Noisy Eater

I (circle all that apply):

Gulp Food Chew with Mouth Open/Lips Apart Take Large Bites

Burp After Eating Eat Mostly Soft Foods Get Upset Stomach After Eating

Wash Food Down Find Crumbs on Table/Floor Stick Out Tongue When Eating

Please circle any you are aware of when drinking:

Tongue Comes Out When Drinking Reach with Tongue to Guide Liquids

Puff Cheeks When Drinking Make Facial Grimaces

Burp After Drinking

Evaluation and Treatment History

Please list any other evaluations or therapies that you have had and the outcomes (i.e. speech, occupational, physical therapy, etc.)

Therapy Type Date Outcome

_____

_____

_____

Have you ever been diagnosed by a physician, neurologist, or psychologist as having any type of neurological impairment or syndrome? If yes, please explain:

Do you take any medications, supplements or vitamins?

Medication Amount/How Often Condition

_____
_____
_____

*****The following is to be completed in office on the day of your first visit

The Notice of Privacy Practices form was made available to me and I understand in what ways my Protected Health Information (PHI) may be used.

_____(signature) _____

Patient signature Date