HISTORY - MBGR

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Name: _____ **Gender F ( ) M ( )**

Examination date: __ / __ / __ **Age:** ___ **years and** ___ **months** **Birth:** __ / __ / __

Responsible: _____ **Relative:** _____ **Marital status** _____

Studying: ❒ yes ❒ no Grade: _____

Working: ❒ yes ❒ no Profession: _____

Worked before ❒ no ❒ yes Professional Area: _____

Practicing sports: ❒ no ❒ yes What: _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: Home: (____) _____ Office: (____) _____ Cell: (____) _____

e-mail: _____

Father's name: _____ **Mother's name:** _____

Siblings: ❒no ❒ yes How many: _____

Who referred patient for evaluation *(Name, specialist, phone)*:

_____

Main complaint: _____

Other complaints affecting: (0) no (1) sometimes (2) yes

( ) lips	( ) tongue	( ) sucking	( ) chewing	( ) deglutition
( ) breathing	( ) speech	( ) tongue frenulum	( ) voice	( ) hearing
( ) learning	( ) facial aesthetic	( ) posture	( ) occlusion	( ) headache
( ) TMJ clicking	( ) TMJ pain	( ) neck pain	( ) shoulder pain	( ) other
( ) mandible range of motion	( ) mouth opening difficulty			

Family history

❒ no ❒ yes What kind: _____

Intercurrences

During pregnancy: ❒ no ❒ yes What kind: _____

At birth: ❒ no ❒ yes. What kind: _____

Motor development

Sitting: ❒ adequate ❒ altered When: _____

Walking: ❒ adequate ❒ altered When: _____

Motor difficulties: (0) no (1) sometimes (2) yes

[ ] running [ ]dressing [ ] tying shoes [ ] buttoning [ ] riding a bike [ ] Other: _____

Health problems

			What	Treatment	Medication
Neurological:	❒ no	❒ yes	_____	_____	_____
Orthopedic:	❒ no	❒ yes	_____	_____	_____
Metabolic:	❒ no	❒ yes	_____	_____	_____
Digestive:	❒ no	❒ yes	_____	_____	_____
Hormonal:	❒ no	❒ yes	_____	_____	_____

Other problems: _____

Breathing problems

			Annual frequency	Treatment	Medication
Frequent colds*:	❒ no	❒ yes			
Throat problems:	❒ no	❒ yes			
Tonsils:	❒ no	❒ yes			
Halitosis:	❒ no	❒ yes			
Asthma:	❒ no	❒ yes			
Bronchitis:	❒ no	❒ yes			
Pneumonia:	❒ no	❒ yes			
Rhinitis:	❒ no	❒ yes			
Sinusitis:	❒ no	❒ yes			
Nasal obstruction:	❒ no	❒ yes			
Nasal itching:	❒ no	❒ yes			
Runny nose:	❒ no	❒ yes			
Sneezing in a row:	❒ no	❒ yes			

* **Frequent colds**: *children up to 5 years old - over 12colds a year*
between 6 and 12 years old – over 6 colds a year

Other problems: _____

Sleep

Restless sleep:	❒ no	❒ sometimes	❒ yes
Snoring:	❒ no	❒ sometimes	❒ yes
Slobbing:	❒ no	❒ sometimes	❒ yes
Apnea:	❒ no	❒ sometimes	❒ yes
Water intake at night:	❒ no	❒ sometimes	❒ yes
Sleeping with mouth open:	❒ no	❒ sometimes	❒ yes
Waking up with a dry mouth:	❒ no	❒ sometimes	❒ yes
Pain in the face when wake up:	❒ no	❒ sometimes	❒ yes
Posture:	❒ side	❒ back	❒ stomach
Hand resting on the face:	❒ no	❒ sometimes [ ] R [ ] L	❒ yes [ ] R [ ] L

Other problems: _____

Treatments

				reason	Professional
SLPs:	❒ no	❒done	❒ current		
Physician:	❒ no	❒done	❒ current		
Psychological :	❒ no	❒ done	❒ current		
Physiotherapy:	❒ no	❒ done	❒ current		
Dental: **Procedure:**	❒ no ❒ exodontia	❒ done ❒prosthesis	❒ current ❒ implant	❒ fixed device	❒ removable device
Surgery:	❒ no	❒ yes. What? _____			When: _____

Other problems: _____

_____

Feeding

Breastfeeding:	❒ yes. Until: _____	❒ no
Bottle:	❒ yes. Until: _____	❒ no

Feeding – difficulty

Glass:	❒ no	❒ yes *(describe)*: _____
Flavors:	❒ no	❒ yes*(describe):* _____
Consistencies:	❒ no	❒ yes *(describe):* _____

Current feeding

				What
Fruits:	❒ no	❒ sometimes	❒ yes	
Greens:	❒ no	❒ sometimes	❒ yes	
Vegetables:	❒ no	❒ sometimes	❒ yes	
Cereals ***(rice, oat, wheat):***	❒ no	❒ sometimes	❒ yes	
Grains ***(beans, lentils, peas):***	❒ no	❒ sometimes	❒ yes	
Meat:	❒ no	❒ sometimes	❒ yes	
Milk and dairy products:	❒ no	❒ sometimes	❒ yes	
Sugar:	❒ no	❒ sometimes	❒ yes	

Diet predominantly

❒ liquid	❒ pasty	❒ solid

Activities during meals

Eating only:	❒ at the table	❒ on the couch	❒ on the floor	❒ in bed
Reading:	❒ at the table	❒ on the couch	❒ on the floor	❒ in bed
Watching TV:	❒ at the table	❒ on the couch	❒ on the floor	❒ in bed
Doing homework:	❒ at the table	❒ on the couch	❒ on the floor	❒ in bed
Using computer:	❒ at the table	❒ on the couch	❒ on the floor	❒ in bed

Chewing

Side:	❒ bilateral	❒ unilateral: [ ] R	[ ] L	
Lips:	❒ closed	❒ half-open	❒ open	
Noise:	❒ no	❒ sometimes	❒ yes	
Drinking during meals:	❒ no		❒ sometimes: [ ] always [ ] help to form a bolus ❒ yes: [ ] always [ ] help to form a bolus	
Pain or discomfort:	❒ no		❒ sometimes: [ ] R [ ] L	❒ yes: [ ] R [ ] L
TMJ noise:	❒ no	❒ sometimes: [ ] R [ ] L	❒ yes: [ ] R [ ] L	
Chewing difficulties:	❒ no	❒ yes	What:	
Food escape:	❒ no		❒ yes	

Other problems: _____

_____

Chewing

❒ adequate	❒ short time	❒ long time

Chewing speed

	similar	**faster**	**slower**
Comparing to the family:	❒	❒	❒
Comparing to friends:	❒	❒	❒

Chewing capacity (how the patient sees his/her chewing)

❒ excellent	❒ good	❒ regular	❒ bad	❒ very bad

Swallowing

Difficulties:	❒ no	❒ sometimes	❒ yes: _____
Noise:	❒ no	❒ sometimes	❒ yes: _____
Choking:	❒ no	❒ sometimes	❒ yes: _____
Odynophagia:	❒ no	❒ sometimes	❒ yes: _____
Nasal reflux:	❒ no	❒ sometimes	❒ yes: _____
Anterior escape:	❒ no	❒ sometimes	❒ yes: _____
Hawking:	❒ no	❒ sometimes	❒ yes: ( ) during ( ) after_____
Cough:	❒ no	❒ sometimes	❒ yes: ( ) during ( ) after_____
Residue after swallowing:	❒ no	❒ sometimes	❒ yes: _____

Other problems: _____

_____

Oral habits

Pacifier:	❒ no	❒ yes	Until: _____ [ ] regular [ ] orthodontic
Thumb sucking:	❒ no	❒ yes	Until: _____
Tongue sucking:	❒ no	❒ yes	Until: _____
Lip liking:	❒ no	❒ yes	When: _____
Cigarette:	❒ no	❒ yes	How many a day: _____
Pipe:	❒ no	❒ yes	[ ] right [ ] left
Bruxism:	❒ no	❒ yes	[ ] day [ ] night
Grinding:	❒ no	❒ yes	When: _____
Nail biting:	❒ no	❒ yes	When: _____
Cheek biting:	❒ no	❒ yes	When: _____
Other biting habits:	❒ no	❒ yes	What: _____ When _____

Other: _____

_____

Posture habits

Lower lip sucking:	❒ no	❒ yes
Mandible protruding:	❒ no	❒ yes
Hand resting on chin:	❒ no	❒ yes: [ ] R [ ] L
Head resting on hand:	❒ no	❒ yes: [ ] R [ ] L
Excessive computer use:	❒ no	❒ yes: posture: _____
Excessive phone use:	❒ no	❒ yes: posture: _____

Other: _____

_____

Communication

Express well: ❒ yes		❒ no
Lack of babbling:		❒ no ❒ yes
Late-talking: ❒ no	❒ yes	
Late sentence structuring: ❒ no		❒ yes
Understanding difficulty: ❒ no		❒ yes

Other problems: _____

_____

Speech

Omission: ❒ no	❒ sometimes	❒ yes	
Substitution: ❒ no	❒ sometimes	❒ yes	
Difficult to understand: ❒ no		❒ sometimes	❒ yes
Difficult to understand on the phone: ❒ no		❒ sometimes	❒ yes
Excessive saliva: ❒ no	❒ sometimes	❒ yes	
Restrict mandible movements: ❒ no			❒ sometimes ❒ yes
Tongue protrusion: ❒ no	❒ yes: [ ] anterior [ ] lateral		What phones: _____

Other problems: _____

_____

Hearing

Hearing loss: ❒ no	❒ sometimes: [ ] R [ ] L	❒ yes: [ ] R [ ] L	
Otitis: ❒ no	❒ sometimes: [ ] R [ ] L	❒ yes: [ ] R [ ] L	
Buzzing: ❒ no	❒ sometimes: [ ] R [ ] L	❒ yes: [ ] R [ ] L	
Otalgy: ❒ no	❒ sometimes: [ ] R [ ] L	❒ yes: [ ] R [ ] L	
Dizziness /Vertigo: ❒ no	❒ sometimes	❒ yes	
Previous audiological assessment: ❒ no	❒ yes. When: _____		

Other problems: _____

_____

Voice

Hoarseness:	❒ no	❒ sometimes	❒ yes
Weakness:	❒ no	❒ sometimes	❒ yes
Hypernasality:	❒ no	❒ sometimes	❒ yes
Hyponasality:	❒ no	❒ sometimes	❒ yes
Aphonia:	❒ no	❒ sometimes	❒ yes
Screaming:	❒ no	❒ sometimes	❒ yes
Pain:	❒ no	❒ sometimes	❒ yes
Throat burning:	❒ no	❒ sometimes	❒ yes

Other problems: _____

_____

Education

Learning difficulties:	❒ no	❒ yes	What: _____
Lack of concentration:	❒ no	❒ sometimes	❒ yes
Memory difficulties:	❒ no	❒ yes	
Fail:	❒ no	❒ yes	How many times: _____
Relationship difficulties:	❒ no	❒ yes	
Handedness:	❒ right-handed	❒ left-handed	❒ both hands

Other problems: _____

_____

_____

_____

SLPs responsible: _____Id number:_____