

MICHIGAN HEAD & NECK INSTITUTE

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Telephone: _____ Birth date: _____ Social Security No: _____
 Male Female Married Widowed Divorced Single
 Family Physician: _____ Phone no: _____
 Family Dentist: _____ Phone no: _____
 When was your last dental appointment? _____
 Emergency contact person: _____ Phone no: _____
 Relationship of emergency contact person: _____

MEDICATIONS

Please list all medications (prescribed or over the counter), vitamins, or herbal remedies you are currently taking:

Please check the following symptoms that apply to your condition

SYMPTOMS

Do you get headaches? Yes No

HEAD PAIN	What Side			Pain Level			How often do you get the pain			Duration (how long does your pain last)					
	Location	Right	Left	Both	Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
Front of your head															
Entire Head															
Top of your head															
Back of your head															
In your temples															

Do you have facial pain? Yes No

FACIAL PAIN	Pain Level			How often do you get the pain			Duration (how long does your pain last)					
	Location	Mild	Moderate	Severe	Occasional	Frequent	Constant	Seconds	Minutes	Hours	Days	Weeks
Left Side												
Right Side												
Both Sides												

Do you have jaw pain? Yes No

JAW PAIN	Right	Left	Both	Neither		Right	Left	Both	Neither
	On Opening						At Rest		
On Wide Opening					Jaw Popping & Grinding				
On side to side movement					Jaw Clicking on Opening				
On Closing					Jaw Clicking on Closing				
While Chewing									

Please circle what applies to your jaw problem

JAW PROBLEMS

On Opening jaw moves to the	Right	Left
Cannot move jaw to	Right	Left
Jaw Locks	Open	Closed

EYE RELATED CONDITIONS

- | | |
|--|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Pain or pressure behind eyes |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Photophobia (extreme sensitivity to light) |
| <input type="checkbox"/> Swelling below eyes | <input type="checkbox"/> Lacrimation (excessive watering) |
| <input type="checkbox"/> Pain in eye (<input type="checkbox"/> Right <input type="checkbox"/> Left) | <input type="checkbox"/> Other: _____ |

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Please check the following conditions that apply to your medical history

ALLERGIES

- Hay fever
- Allergic to: (please list medications or other)

ARTHRITIS

- Gout
- Osteoarthritis
- Rheumatoid Arthritis
- Other: _____

ENDOCRINE DISORDERS

- Diabetes
- Hypoglycemia
- Parathyroid Disease
- Thyroid Disease
- Other: _____

EYE DISORDERS

- Glaucoma
- Ocular Herpes
- Other: _____

HIV DISORDERS

- AIDS
- ARC
- Tested HIV positive
- Other: _____

KIDNEY/URINARY DISORDERS

- Bladder Infections
- Blood in Urine
- Kidney Disease
- Sugar in Urine
- Other: _____

MUSCLE DISORDERS

- Muscular Dystrophy
- Other: _____

NERVE DISORDERS

- Cerebral Palsy
- Epilepsy
- Neuralgia
- Multiple Sclerosis
- Parkinson's Disease
- Stroke
- Other: _____

ARTIFICIAL IMPLANTS

- Heart Pacemaker
- Heart Valve
- Joint Prosthesis
- Other: _____

BLOOD DISORDERS

- Anemia
- Bleeding Easily
- Hemophilia
- Leukemia
- Sickle Cell Anemia
- Other: _____

HEART/CIRCULATORY DISORDERS

- Arteriosclerosis
- Congenital Heart Disorders (at birth)
- Coronary Artery Disease
- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- Poor Circulation
- Rheumatic Fever
- Other: _____

LIVER DISEASE

- Cirrhosis of the liver
- Hepatitis A (Infectious)
- Hepatitis B (Serum)

LUNG/RESPIRATORY DISORDERS

- Asthma
- Chronic Colds
- Emphysema
- Frequent Cough
- Lung Cancer
- Shortness of Breath
- Tuberculosis
- Other: _____

STOMACH/INTESTINAL DISORDERS

- Colitis
- Ulcers
- Other: _____

OTHER MEDICAL CONDITIONS

- Addiction to alcohol
- Addiction to drugs
- Bruising easily
- Chemotherapy
- Chronic fatigue
- Excessive Thirst
- Frequent stressful situations
- Nervousness
- Osteoporosis
- Psychiatric care
- Radiation Treatment
- Scarlet Fever
- Other: _____

Patient Signature: _____ Date: _____

EAR RELATED CONDITIONS

- Buzzing in the ears
- Dizziness
- Hearing loss
- Recurrent infections
- Sensitivity to some sounds
- Congestion/Stuffiness
- Earache: Right Left Both
- Pain in front of the ear: Right Left Both
- Pain behind the ear: Right Left Both
- Tinnitus (ringing or roaring in ear): Right Left Both

OTHER RELATED CONDITIONS

- Back pain (lower)
- Back pain (upper)
- Back pain radiating to the neck
- Shoulder pain
- Neck pain
- Limited movement of the neck
- Stiffness in neck
- Numbness or tingling in the hand or fingers Right Left Both
- Constant sore throat
- Difficulty in swallowing
- Swelling in the neck
- Swollen glands
- Swollen lymph nodes
- Thyroid enlargement
- Other: _____

MOUTH AND NOSE RELATED CONDITIONS

- Chronic Sinusitis
- Frequent biting of the cheek
- Frequent biting of the lip
- Burning tongue
- Do you snore?
- Other: _____
- Dry mouth
- Broken teeth
- Sensitive or sore teeth Right Left
- Numbness, Where? _____
- Tired during the day

EMOTIONAL CONDITIONS

- Depression
- Irritability
- Fear and/or avoidance
- Anxiety
- Crying for no reason
- Mood swings
- Nightmares
- Fear of: _____
- Insomnia (difficulty sleeping)
- Relationship changes
- Diminished libido (lowered sex drive)
- Argumentative
- Panic attacks
- Change in personality
- Fear of driving
- Other: _____

COGNITIVE CONDITIONS

- Difficulty expressing myself
- Confusion
- Disorientation to person, place, or time
- Memory difficulty
- Difficulty with map directions
- Difficulty finding the right word
- Difficulty concentrating
- Difficulty starting new tasks
- Difficulty completing tasks
- Difficulty understanding what you hear
- Difficulty understanding what you read
- Decreased organization
- Difficulty with speech
- Difficulty with attention

What makes your pain worse? _____

What do you believe is the cause of your pain or condition?

- An automobile accident (Date: _____)
- A motorcycle accident (Date: _____)
- A work-related accident (Date: _____)
- A slip and fall accident (Date: _____)
- Other: _____

What other information is important to your condition? _____

Patient Signature: _____ Date: _____

WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT?

Please number the complaints with #1 being the most important.

- | | |
|---|---|
| <input type="checkbox"/> Frequent heavy snoring | <input type="checkbox"/> Morning hoarseness |
| <input type="checkbox"/> _____ which affects the sleep of others | <input type="checkbox"/> Morning headaches |
| <input type="checkbox"/> Significant daytime drowsiness | <input type="checkbox"/> Swelling in ankles or feet |
| <input type="checkbox"/> I have been told that "I stop breathing" when sleeping | <input type="checkbox"/> Nocturnal teeth grinding |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Jaw pain |
| <input type="checkbox"/> Gasping when waking up | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Nighttime choking spells | <input type="checkbox"/> Jaw clicking |
| <input type="checkbox"/> Feeling unrefreshed in the morning | |

Other: _____

c
How likely are you to doze off or fall asleep in the following situations?

	0 No chance of dozing	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g. a theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Patient Signature: _____ Date: _____

Have you ever had an evaluation at a Sleep Center Yes ___ No ___

If Yes:

Sleep Center Name _____

And location _____

Sleep Study Date _____

FOR OFFICE USE ONLY

The evaluation confirmed a diagnosis of: Mild ___, Moderate ___, Severe ___, obstructive sleep apnea

The evaluation showed an RDI of _____ and an AHI of _____

CPAP Intolerance (Continuous Positive Airway Pressure device)

If you have attempted treatment with a CPAP device, but could not tolerate it please fill in this section:

I could not tolerate the CPAP device due to:

- mask leaks
- I was unable to get the mask to fit properly
- discomfort caused by the straps and headgear
- disturbed on interrupted sleep caused by the presence of the device
- noise from the device disturbing my sleep and/or bed partner's sleep
- CPAP restricted movements during sleep
- CPAP does not seem to be effective
- pressure on the upper lip causing tooth related problems
- of a latex allergy
- claustrophobic associations
- an unconscious need to remove the CPAP apparatus at night

Other: _____

OTHER THERAPY ATTEMPTS

What other therapies have you had for breathing disorders?
(weight-loss attempts, smoking cessation for at least one month, surgeries, etc.)

SOCIAL HISTORY

Alcohol consumption: How often do you consume alcohol within 2-3 hours of bedtime?
___ Never ___ Once a week ___ Several days a week ___ Daily

Sedative consumption: How often do you take sedatives within 2-3 hours of bedtime?
___ Never ___ Once a week ___ Several days a week ___ Daily

Caffeine consumption: How often do you consume caffeine within 2-3 hours of bedtime?
___ Never ___ Once a week ___ Several days a week ___ Daily

Tobacco consumption: ___ Non -Smoker ___ Smoker ___ number of packs per day

Patient Signature: _____ Date: _____

It may be important for us to communicate our recommendations for you with other doctors. Please list all of the names and addresses of doctors that you are currently seeing, even if it is not for pain.

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N

Name: _____
Address: _____

Phone: () _____
What type of doctor is this?

Do you want a report sent to this Dr.? Y/N



Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- * A basis for planning my care and treatment
- * A means of communication among the many health professionals who contribute to my care
- * A source of information for applying my diagnosis and surgical information to my bill
- * A means by which a third-party payer can verify that services billed were actually provided, and
- * A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information used and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations.

I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

Signature _____

Date _____

For office use only

- [] Consent received by _____ on _____
- [] Consent refused by patient, and treatment refused as permitted
- [] Consent added to the patient's medical record on _____