

MICHIGAN HEAD & NECK INSTITUTE
3665 E. ELEVEN MILE ROAD
WARREN, MI 48092
586-573-0438

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Contact Phone #: _____ Birth date: _____ Social Security #: _____

Additional Phone #: _____ Email: _____

Male Female Married Widowed Divorced Single

Family Physician: _____ Phone #: _____

Family Dentist: _____ Phone #: _____

When was your last dental appointment? _____

Emergency contact person: _____ Phone #: _____

Relationship of emergency contact person: _____

EMPLOYMENT INFORMATION

Employer Name: _____ Phone #: _____

Employer Address: _____ Your Job title: _____

Are you presently working? Yes No. If no, when was your last day worked? _____

Have you missed any work due to your present condition? (Please give dates) _____

The most difficult tasks while at work are/were _____

Spouse or guardian's place of employment

Spouse/Guardian Name: _____ Relationship: _____

Spouse/Guardian Employer Name: _____ Phone: _____

Spouse/Guardian Employer Address: _____

PLEASE BRING TO THIS APPOINTMENT ANY TYPE OF MOUTH GUARD YOU HAVE

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

MEDICAL HISTORY

Please check the following conditions that apply to your medical history

ALLERGIES

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

Allergic to: Acrylic, Nickel, Tape, or other)

ARTHRITIS

- Gout
 Osteoarthritis
 Rheumatoid Arthritis
 Other: _____

ENDOCRINE DISORDERS

- Diabetes
 Hypoglycemia
 Parathyroid Disease
 Thyroid Disease
 Other: _____

STOMACH/INTESTINAL DISORDERS

- Colitis
 Ulcers
 Other: _____

EYE RELATED CONDITIONS

- Blurred Vision
 Double Vision
 Swelling below eyes
 Pain in eye: Right Left Both
 Pain or pressure behind eyes
 Photophobia (extreme sensitivity to light)
 Lacrimation (excessive watering)
 Other: _____

EAR RELATED CONDITIONS

- Buzzing in the ears: Right Left Both
 Dizziness
 Hearing loss: Right Left Both
 Sensitivity to some sounds: Right Left Both
 Recurrent infections: Right Left Both
 Congestion/Stuffiness: Right Left Both
 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

I have read the above conditions and none apply to me.

ARTIFICIAL IMPLANTS

- Heart Pacemaker
 Heart Valve
 Joint Prosthesis
 Other: _____

BLOOD DISORDERS

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

KIDNEY/URINARY DISORDERS

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

HIV DISORDERS

- AIDS
 ARC
 Tested HIV positive
 Other: _____

EYE DISORDERS

- Glaucoma
 Ocular Herpes
 Other: _____

MOUTH AND NOSE CONDITIONS

- Chronic Sinusitis
 Frequent biting of the cheek
 Frequent biting of the lip
 Burning tongue
 Do you snore? Yes No
 Dry mouth
 Broken teeth
 Sensitive or sore teeth Right Left
 Numbness, Where? _____
 Other: _____
 Tired during the day

Patient Signature: _____ Date: _____

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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: _____

MUSCLE DISORDERS

- Muscular Dystrophy
 Other: _____

LIVER DISEASE

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

HEART/CIRCULATORY DISORDERS

- Arteriosclerosis
 Congenital Heart Disorders (at birth)
 Coronary Artery Disease
 Heart Murmur
 High Blood Pressure (hypertension)
 Low Blood Pressure
 Poor Circulation
 Rheumatic Fever
 History of Stroke
 Ischemic Heart Disease
 Cardiopulmonary and upper airway system evaluation
 Date _____ Dr. Name _____
 Other: _____

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
 Difficulty in swallowing
 Constant sore throat Swelling in the neck
 Swollen lymph nodes Swollen glands
 Thyroid enlargement
 Numbness or tingling in the hand or fingers
 Right Left Both
 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

NERVE DISORDERS

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

LUNG/RESPIRATORY DISORDERS

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

I have read the above conditions and none apply to me.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

MEDICATIONS

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

What are the chief complaints for which you are seeking treatment?

What treatment if any, have you had for this problem? Please list the doctor(s) name and phone number(s) that performed this treatment.

What helps your condition? _____

What makes it worse? _____

Are you able to perform normal household activities? Yes No Are you incapacitated? Yes No

Have you ever had any symptoms of a TMJ disorder? Yes No

Has a physician or dentist ever diagnosed you with a TMJ disorder? Yes No

SYMPTOMS

Do you experience headaches? Yes No If yes, please check the boxes that apply

HEAD PAIN Location	What Side			Pain Level			How often do you get the pain			Duration (how long does your pain last)				
	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 If yes, please check the boxes that apply

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

Do you have jaw pain? Yes No If yes, please check the boxes that apply

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									

Do you have jaw problems? Yes No If yes, please circle what applies to your jaw problem

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

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

SYMPTOMS CONTINUED

Do you have a fever with your headache? YES NO
 Do you have a stiff neck with your headache? YES NO
 Have you been getting your headaches for six months or less? YES NO
 Do you get severe headaches with severe onset? YES NO
 Have your headaches been getting progressively worse? YES NO
 Do you ever pass out or lose any of your senses when you have a headache? YES NO
 Did your headache problem begin after a trauma or an injury? NO YES
 If Yes, When _____

Were you diagnosed with a closed head injury? YES NO

If yes, by which Dr.? _____

Have you had a weight change greater than 5 pounds in the last year? NO YES Gained ___ lbs/Lost ___ lbs

Do you have difficulty breathing through your nose at night? YES NO
 Have you ever been treated for difficulty breathing through your nose? YES NO
 If you awaken during the night, is it difficult to fall back asleep? YES NO
 During an average night, how many times do you awaken? 1 2 3 4 5 6 7 8
 On the average, how many hours do you sleep a night? 1 2 3 4 5 6 7 8 9 10
 Have immediate family members had sleep disorders? YES NO
 Do you have difficulty finding the energy to do your daily activities? YES NO
 Circle your usual sleep position or positions *Back Side Stomach Varies*

Do you frequently wake up in the morning with a headache or get one shortly after awakening? YES NO

Have you ever had a sleep study? YES NO

Did you receive a diagnosis of obstructive sleep apnea? YES NO

Sleep Study Date _____

Name of doctor making the diagnosis _____

Specialty of health care provider making the diagnosis? _____

What was your Apnea-Hypopnea Index? _____

Name and location of Sleep Lab _____

Has a CPAP (*Continuous Positive Airway Pressure*) Device ever been recommended for you to wear?

YES NO

Please check other therapies performed to help your sleep apnea

___ Exercise ___ Palatal Surgery ___ Nasal Surgery ___ Maxilla Surgery ___ Weight Loss ___

Tongue Surgery

___ Smoking Cessation ___ Mandibular Advancement Oral Device ___ Tongue Retaining Device

Other _____

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Please check the following conditions that apply to you:

- | | |
|--|---|
| <input type="checkbox"/> Frequent heavy snoring | <input type="checkbox"/> Morning hoarseness |
| <input type="checkbox"/> Snoring that 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 "You 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"/> Not feeling refreshed in the morning | |
| Other: _____ | <input type="checkbox"/> None |

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

Use the following scale to choose the most appropriate number for each situation

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

- | | |
|---|---|
| _____ Sitting and reading | _____ Lying down to rest in the afternoon when able |
| _____ Sitting and talking to someone | _____ Sitting quietly after lunch without alcohol |
| _____ In car stopped momentarily in traffic | _____ Watching television |
| _____ Sitting inactive in public (theater or meeting) | _____ As a passenger in a car for an hour without a break |
| Total _____ | |

Have you ever used a CPAP (Continuous Positive Airway Pressure) device for treatment of snoring or sleep apnea? Yes _____ No _____

If you could not tolerate the CPAP please check the following that apply:

- | | |
|---|---|
| <input type="checkbox"/> Discomfort caused by the straps and headgear | <input type="checkbox"/> A latex allergy |
| <input type="checkbox"/> CPAP restricted movements during sleep | <input type="checkbox"/> Claustrophobic associations |
| <input type="checkbox"/> Disturbed or interrupted sleep caused by the presence of the device | <input type="checkbox"/> Mask leaks |
| <input type="checkbox"/> Noise from the device disturbing my sleep and/or bed partner's sleep | <input type="checkbox"/> CPAP does not seem to be effective |
| <input type="checkbox"/> An unconscious need to remove the CPAP apparatus at night | <input type="checkbox"/> I was unable to get the mask to fit properly |
| <input type="checkbox"/> Pressure on the upper lip causing tooth related problems | |

Other: _____

SOCIAL HISTORY

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

Alcohol consumption: How often do you consume alcohol?

_____ Never _____ Once a week _____ Several days a week _____ Daily

How often do you consume alcohol within two hours of bedtime?

_____ Never _____ Once a week _____ Several days a week _____ Daily

I attest that the information provided is complete and accurate to the best of my ability.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

It may be helpful 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: () _____

Fax: () _____

Type of doctor _____

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

Name: _____

Address: _____

Phone: () _____

Fax: () _____

Type of doctor _____

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

Name: _____

Address: _____

Phone: () _____

Fax: () _____

Type of doctor _____

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

Name: _____

Address: _____

Phone: () _____

Fax: () _____

Type of doctor _____

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Phone: () _____

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Phone: () _____

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Name: _____

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Phone: () _____

Fax: () _____

Type of doctor _____

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Name: _____

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Fax: () _____

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

I, the patient, 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
- * A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

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. 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.

I understand that as part of this organizations treatments, 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 understand that a Notice of Information Practices will be provided to me upon request

I fully understand and ACCEPT/DECLINE the terms of this content.

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____