

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 #: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ 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 ANY TYPE OF MOUTH GUARD YOU HAVE TO THIS APPOINTMENT**

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  Itchy Ears  Right  Left  Both
- 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.

**Has any blood relatives (parent, brother/sister, grandparent) had any of the above listed conditions:**

Yes or No. If yes, list who and which conditions: \_\_\_\_\_

**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: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**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
- Low Blood Pressure
- Poor Circulation
- Rheumatic Fever
- 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*  
 How often do you consume alcohol? *Never Once/week Several times/week Daily Socially*  
 How often do you consume alcohol within two hours of bedtime? *Never Once/week Several times/week Daily*

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

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: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

Type of doctor \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Michigan Head & Neck Institute**

3665 E. Eleven Mile Road  
Warren, MI 48092  
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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: \_\_\_\_\_





[www.michiganheadandneck.com](http://www.michiganheadandneck.com)

586-573-0438

**75% of TMD PATIENTS HAVE SLEEP APNEA**

If left untreated, sleep apnea can result in a growing number of health problems, including:

- High blood pressure (hypertension)
- Stroke
- Heart failure, irregular heartbeats, and heart attacks
- Diabetes
- Obesity
- Insomnia
- Depression and mood disorders
- Lowered sex drive
- GERD or Acid Reflux
- Worsening of ADHD
- Cancer
- Headaches and migraines
- Pulmonary embolism
- Traffic or workplace accidents
- Dementia
- TMJ Disorders
- Death