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 [] Other_____ [] 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

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

[ ] 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: _____

_____

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 (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.

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: _____

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	**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 If yes, please check the boxes that apply

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 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_____ Date of Last Visit _____
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:

[ ] Frequent heavy snoring
[ ] Snoring that affects the sleep of others
[ ] Significant daytime drowsiness
[ ] I have been told "You stop breathing" when sleeping
[ ] Difficulty falling asleep
[ ] Gasping when waking up
[ ] Nighttime choking spells
[ ] Not feeling refreshed in the morning
Other: _____

[ ] Morning hoarseness
[ ] Morning headaches
[ ] Swelling in ankles or feet
[ ] Nocturnal teeth grinding
[ ] Jaw pain
[ ] Facial pain
[ ] Jaw clicking

[ ] 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
_____Sitting and talking to someone
_____In car stopped momentarily in traffic
_____Sitting inactive in public (theater or meeting)
Total _____

_____Lying down to rest in the afternoon when able
_____Sitting quietly after lunch without alcohol
_____Watching television
_____As a passenger in a car for an hour without a break

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:

[ ] Discomfort caused by the straps and headgear
[ ] CPAP restricted movements during sleep
[ ] Disturbed or interrupted sleep caused by the presence of the device
[ ] Noise from the device disturbing my sleep and/or bed partner's sleep
[ ] An unconscious need to remove the CPAP apparatus at night
[ ] Pressure on the upper lip causing tooth related problems

[ ] A latex allergy
[ ] Claustrophobic associations
[ ] Mask leaks
[ ] CPAP does not seem to be effective
[ ] I was unable to get the mask to fit properly

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 ____________________
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 ____________________
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 ____________________
Do you want reports 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
586-573-0438

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 competency 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 organization's 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: _____

MICHIGAN
HEAD & NECK
INSTITUTE, PC

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