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

Patient Name: First _____ Middle _____ Last _____

Address: _____ Apt./Unit #:_____ City:_____ State:_____ Zip:_____

Employer_____ Home Phone #_____ Cell Phone #_____

Email:_____ SSN:_____ Physician's name:_____ Physician's #_____

Dentist's name:_____ Dentist's #:_____ Date of last physical:_____

Date of Birth:_____ Emergency Contact:_____ Emergency Contact #:_____

Spouse Name _____ Spouse's Phone # _____

Place a mark on "yes" or "no" to each:

AIDs/HIV	❑Yes ❑No	Heart Lesions	❑Yes ❑No	Thyroid Problems	❑Yes ❑No
Anemia	❑Yes ❑No	Heart Murmur	❑Yes ❑No	Tonsillitis	❑Yes ❑No
Arthritis	❑Yes ❑No	Heart Problems	❑Yes ❑No	Tuberculosis	❑Yes ❑No
Artificial Heart Valves	❑Yes ❑No	Hepatitis Type _____	❑Yes ❑No	Tumor or growth on head or neck	❑Yes ❑No
Artificial Joints	❑Yes ❑No	High Blood Pressure	❑Yes ❑No	Ulcer	❑Yes ❑No
Asthma	❑Yes ❑No	Kidney Disease	❑Yes ❑No		
Bleeding abnormally with extractions or surgery	❑Yes ❑No	Liver Disease	❑Yes ❑No		
		Mitral Valve Prolapse	❑Yes ❑No		
Blood Disease	❑Yes ❑No	Neurological Issues	❑Yes ❑No		
Cancer	❑Yes ❑No	Pacemaker	❑Yes ❑No		
Chemotherapy	❑Yes ❑No	History Infective Carditis	❑Yes ❑No		
Circulatory Problems	❑Yes ❑No	Psychiatric Care	❑Yes ❑No		
		Emotional Conditions (depression/anxiety/etc.)	❑Yes ❑No		
Cortisone Treatments	❑Yes ❑No	Radiation Treatment	❑Yes ❑No		
Cognitive Issues (e.g. memory loss, ADHD, etc.)	❑Yes ❑No	Scarlet Fever	❑Yes ❑No		
Diabetes Type _____	❑Yes ❑No	Sleep Apnea (or family history of sleep apnea)	❑Yes ❑No		
Epilepsy	❑Yes ❑No	Bell's Palsy	❑Yes ❑No		
Fainting or dizziness	❑Yes ❑No	Stroke	❑Yes ❑No		
Glaucoma	❑Yes ❑No				

List any allergies to medications or other substances, such as latex, etc.

_____

_____

Pharmacy name and number:

_____

List all current medications and supplements:

_____

_____

_____

Have you...?

Seen an orthodontist ❑Yes ❑No
Had TMJ joint surgery ❑Yes ❑No

Have you ever seen a(n)...?

ENT Professional ❑Yes ❑No
Chiropractor ❑Yes ❑No
Neurologist ❑Yes ❑No

Have you ever had Botox? ❑Yes ❑No

Do you use a CPAP? ❑Yes ❑No

Have you had radiation on the head/neck? ❑Yes ❑No

Do you consume alcohol? ❑Yes ❑No

Do you use tobacco/vaping products? ❑Yes ❑No

By signing, I understand that Michigan Head and Neck Institute may photograph or video certain procedures for in-office educational purposes, as well as for proper communications with our specialized laboratories.

Signature: _____ Date: _____

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
[ ] Insomnia
[ ] 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
[ ] Jaw clicking
[ ] Facial pain
[ ] Upper body soreness (head/neck/shoulders)

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 (ex. in a theater or meeting)
__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

Total: ___

One or more of the following symptoms may be indicative of a TMJ/TMD disorder. If you have any of the following symptoms, please indicate by marking the appropriate side(s) of your body. Select "Do not experience" if you do not experience the symptom at all.

Pain around/behind eyes	Left	Right	Both	Do not experience
Pain in jaw joints	Left	Right	Both	Do not experience
Pain in lower jaw	Left	Right	Both	Do not experience
Pain in upper jaw	Left	Right	Both	Do not experience
Pain in neck	Left	Right	Both	Do not experience
Pain in shoulder(s)	Left	Right	Both	Do not experience
Pain in forehead	Left	Right	Both	Do not experience
Pain/congestion in sinuses	Left	Right	Both	Do not experience
Pain in temples	Left	Right	Both	Do not experience
Clicking, popping, grating in joints	Left	Right	Both	Do not experience
Ringing sound in ears (tinnitus)	Left	Right	Both	Do not experience
Fullness/pressure in ear	Left	Right	Both	Do not experience

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

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

MICHIGAN HEAD & NECK INSTITUTE, PC

www.michiganheadandneck.com
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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