

MICHIGAN HEAD & NECK INSTITUTE
989 E. South Blvd, Suite 100
Rochester Hills, MI 48307
586-573-0438

Patient Name _____ Address w/ZIP _____
Email _____ SSN # _____ Male ___ Female ___ Other ___
Employer _____ Home Phone # _____ Cell Phone # _____
Physician's Name and # _____ Dentist's Name and # _____
Date of Last Physical _____ Date of Birth _____
Spouse's Name _____ Spouse's Phone # _____
Emergency Contact _____ Emergency Contact's Phone # _____

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

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

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

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:

- | | |
|--|--|
| <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"/> Difficulty breathing through nose |
| <input type="checkbox"/> Insomnia | <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"/> Upper body soreness (head/neck/shoulders) |
| <input type="checkbox"/> Not feeling refreshed in the morning | |
- Other: _____

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 letters and, if appropriate, marking left or right. (L = Left R = Right B = both)

	Left	Right	Neither
Pain around/behind eyes	Left	Right	Neither
Broken/sensitive teeth	Left	Right	Neither
Pain in jaw joints	Left	Right	Neither
Pain in temples	Left	Right	Neither
Pain/congestion in sinuses	Left	Right	Neither
Pain in neck	Left	Right	Neither
Pain in shoulder	Left	Right	Neither
Headaches	Left	Right	Neither
Limited opening	Left	Right	Neither
Clicking, popping, grating in joints	Left	Right	Neither
Ringing sound in ears (tinnitus)	Left	Right	Neither
Fullness/pressure in ear	Left	Right	Neither

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Referral List

(Please indicate any offices you would like to receive a copy of your reports from our office):

Name: _____
Address: _____

Phone: () _____
Fax: () _____
Type of doctor _____

Name: _____
Address: _____

Phone: () _____
Fax: () _____
Type of doctor _____

Name: _____
Address: _____

Phone: () _____
Fax: () _____
Type of doctor _____

Name: _____
Address: _____

Phone: () _____
Fax: () _____
Type of doctor _____

Name: _____
Address: _____

Phone: () _____
Fax: () _____
Type of doctor _____

Name: _____
Address: _____

Phone: () _____
Fax: () _____
Type of doctor _____

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

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____



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