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	❑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		
Asthma	❑Yes ❑No	Kidney Disease	❑Yes ❑No	Ulcer	❑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.

_____

_____

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
[ ] Morning hoarseness
[ ] Morning headaches
[ ] Swelling in ankles or feet
[ ] Difficulty breathing through nose
[ ] Nocturnal teeth grinding
[ ] Jaw pain
[ ] Facial pain
[ ] Upper body soreness (head/neck/shoulders)

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: _____

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