ENT & Audiology Center of Southlake

Michael D. Bryan, M.D.
Diplomate of the American Board of Otolaryngology
Amy K. Mettman, M.D., P.A.
Otolaryngology-Head and Neck Surgery

Patient's Name: _____ **Today's Date:** _____

Date of Birth: _____ **Male / Female**
Reason for Today's Visit:
_____

Pharmacy: Name _____**Location**_____ **Phone**_____

Primary Care Physician: _____ **Phone:** _____ **Fax:** _____

Were you referred by your PCP or another provider?

- ☐ Not referred
- ☐ Yes, PCP
- ☐ Yes, another physician. Physician: _____
  Phone: _____ Fax: _____

If you were not referred by a physician, how did you obtain our practice's name (please circle all that apply):

Internet search / Family/Friend / Phone Book / Insurance Website / Other _____

Current Medications: (include OTC and supplements)
_____
_____
_____
_____

Medical History: (for example: Bleeding disorders, Sleep apnea, Diabetes, Hypertension, High Cholesterol, Asthma)
_____
_____
_____
_____

Are you allergic to any medications?

- ☐ No
- ☐ Yes Allergic to: _____
  _____

Surgical History: (please circle any surgeries you have had, and include year if you can recall)

Ear tubes _____	Septum Repair _____	Skin Cancer _____
Ear drum repair _____	Sinus Surgery _____	Gallbladder _____
Mastoidectomy _____	Thyroid Surgery _____	Appendix _____
Tonsillectomy _____	Hysterectomy _____	
Adenoidectomy _____	C-Section _____	Orthopedic _____

Other_____
_____

Past Hospitalizations: (other than those related to surgeries listed)
_____
_____
_____

660 W. Southlake Blvd, # 100
Southlake, TX 76092

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Patient Name: _____

Family History: (for example: hearing loss, ear surgeries, thyroid disease, cancer, complications with anesthesia, bleeding disorders)

- Father: _____
- Mother: _____
- Paternal Grandfather: _____
- Paternal Grandmother: _____
- Maternal Grandfather: _____
- Maternal Grandmother: _____
- Siblings: _____
- Children: _____

Social History:

- Do you use any tobacco products?
  - □ Never
  - □ Not currently, quit ____months / yrs ago; (circle) Smokeless tobacco or cigarettes? Amount _____for _____yrs
  - □ Yes. (circle) Smokeless tobacco or cigarettes? Amount _____for _____yrs

- Marital Status: Single / Married / Divorced / Widowed / Partner
- Pets: _____
- Do you drink alcohol?
  - □ No
  - □ Yes Number of drinks per week? _____

Are you CURRENTLY experiencing any of the following?

EARS/NOSE/MOUTH/ THROAT

Hearing loss	□ none □ right □ left □ both
Ringing in ears	□ none □ right □ left □ both
Ear pain	□ none □ right □ left □ both
Ear Drainage	□ none □ right □ left □ both
Snoring	□ no □ yes_____
Nasal obstruction	□ no □ yes_____
Nosebleeds	□ no □ yes_____
Mouth sores	□ no □ yes_____
Sore tongue	□ no □ yes_____
Sore throat	□ no □ yes_____
Voice change	□ no □ yes_____
Hoarseness	□ no □ yes_____
Difficulty swallowing	□ no □ yes_____
Painful swallowing	□ no □ yes_____
Good General health	□ no □ yes_____
Easy bleeding	□ no □ yes_____
Easy bruising	□ no □ yes_____
Chest pain	□ no □ yes_____
Cough	□ no □ yes_____
Heartburn	□ no □ yes_____
Frequent Headaches	□ no □ yes_____
Weight changes	□ no □ yes_____
Vision Changes	□ no □ yes_____
Upset Stomach	□ no □ yes_____

ALLERGIC

Hay fever	□ no □ yes_____
Food allergies	□ no □ yes_____
Eye itchiness	□ no □ yes_____
Nose itchiness	□ no □ yes_____
Sneezing	□ no □ yes

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