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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