

**Division of Pediatric Otolaryngology Visit/Consult Note**
**Patient Name:**  
**Patient MRN:**  
**Date of Birth:**
**Date of Exam:**
**Referring Doctor:** \_\_\_\_\_

**CHIEF COMPLAINT:**

The history was obtained from

**Patient / Family Education Given:** YES NO  
**Barriers to Learning:** YES NO  
**S.C.A.N.:** YES NO

HISTORY OF PRESENT ILLNESS – ENT	
Ear	
Nose / Sinus	
Throat / Mouth	
Neck	
Airway	
Duration	HOURS DAYS WEEKS MONTHS YEARS
Location	EARS NOSE THROAT HEAD NECK
Quality	DULL THROBBING SHARP
Severity	MINOR MODERATE SEVERE
Timing	GRADUAL SUDDEN CONSTANT INTERMITTENT
Context / Positives / Negatives	WORSENING RECURRENT NO CHANGES IMPROVING
Modifying Factors	REST POSITION ACTIVITY MEALS
Related Signs/Symptoms	NUMBNESS TINGLING PAIN SMELL BREATHING SWALLOWING
Other	CONSTANT MINUTES MONTHS INTERMITTENT

MEDICAL/SOCIAL/BIRTH/FAMILY HISTORY	
School/Daycare	YES NO
Exp to Smoking	YES NO
Siblings	YES NO
Immunizations	ALL UP TO DATE NOT UP TO DATE
Prenatal Issues	NONE YES (explain):
Hospitalizations	NONE YES (explain):
Prior Surgeries	NONE YES (explain):
Allergies	NONE YES (explain):
Medications & Herbal Supplements	NONE YES (explain):
Family Hx Anesthesia Problems	NONE YES (explain):
Family Hx Bleeding Problems	NONE YES (explain):

REVIEW OF SYSTEMS	
ENT	See ENT HPI
Constitutional	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Cardiovascular	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Respiratory	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Neurological	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Gastrointestinal	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Genitourinary	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Hematology/ Oncology	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Endocrine/ Genetics/ Metabolic	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Allergy/Immunology	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Musculoskeletal	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Skin	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Developmental/ Behavioral	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL
Eyes	<input type="checkbox"/> ALL NORMAL FINDINGS <input type="checkbox"/> ABNORMAL

		EXAMINATION
*Vitals		BP:                      HR:                      RR:                      TEMP:                      HEIGHT:                      WEIGHT:
*Constitutional	<input type="checkbox"/> All Normal Findings	*General Appearance: NORMAL      ABNORMAL (explain): *Ability to Communicate: NORMAL      ABNORMAL (explain): Pain: YES      NO
*Head & Face	<input type="checkbox"/> All Normal Findings	Inspection: NORMOCEPHALIC      ABNORMAL (explain): Scars/Lesions/Masses: YES      NO Edema/Erythema/Tenderness: YES      NO
*Eyes	<input type="checkbox"/> All Normal Findings	Conjunctivae and Lids: NORMAL      ABNORMAL Ocular Motility: EXTRAOCULAR MOVEMENTS INTACT      ABNORMAL
*Ears	<input type="checkbox"/> All Normal Findings	Right EXT:                      Left EXT: Right EAC:                      Left EAC: Right TM:                      Left TM:
*Nose	<input type="checkbox"/> All Normal Findings	*Ext Nose: NORMAL      DORSAL HUMP      DEVIATED LEFT      DEVIATED RIGHT *Septum: NORMAL      DEVIATED LEFT      DEVIATED RIGHT Turbinates: NORMAL      HYPERTROPHIC      POLYPOID      PALE      CONGESTED Nasal Mucosa: NORMAL      ERYTHEMA      PALE/BLUE Rhinorrhea: NONE      SCANT      GREEN/YELLOW      CLEAR/WATERY Foreign Body: NONE      LEFT      RIGHT <input type="checkbox"/> FOREIGN BODY REMOVED  NASAL ENDOSCOPY      YES      NO Adenoids: NORMAL      ENLARGED      INFECTED Eustachian Tubes: NORMAL      ABNORMAL Posterior Choanae: PATENT      OBSTRUCTED Masses: YES      NO Velopharyngeal Insufficiency: YES      NO
*Oral Cavity	<input type="checkbox"/> All Normal Findings	Lips/Teeth/Gums: NORMAL      ABNORMAL Oral Mucosa: NORMAL      ABNORMAL Tongue/Floor of Mouth: NORMAL      ABNORMAL
*Oropharynx	<input type="checkbox"/> All Normal Findings	Oropharynx: NORMAL      CROWDED Palate: NORMAL      CLEFT      FORESHORTENED Uvula: NORMAL      LONG      EDEMA      BIFID Tonsils: NORMAL      1+      2+      3+      4+      ERYTHEMA      EXUDATE
Larynx	<input type="checkbox"/> All Normal Findings	FLEXIBLE ENDOSCOPY      YES      NO Base of Tongue      NORMAL      ENLARGED      GLOSSOPTOSIS Epiglottis      NORMAL      OMEGA-SHAPED      RETROFLEXED Ariepiglottic Folds      NORMAL      FORESHORTENED Pyriform Sinuses      NORMAL      POOLING      ASYMMETRY Pharyngeal Walls      NORMAL      ABNORMAL Vocal Cord Mobility      NORMAL      ABNORMAL True Folds      NORMAL      ABNORMAL False Folds      NORMAL      ABNORMAL Arytenoids      NORMAL      ERYTHEMA      EDEMA Cricopharyngeus      NORMAL      ABNORMAL
TMJ	<input type="checkbox"/> All Normal Findings	LEFT: TENDERNESS      CREPITUS      CLICKING      CROSSBITE RIGHT: TENDERNESS      CREPITUS      CLICKING      CROSSBITE
*Cervical	<input type="checkbox"/> All Normal Findings	Trachea: NORMAL/MIDLINE      ABNORMAL Thyroid: NORMAL      LARGE      TENDER      MASS Salivary Glands: NORMAL      LARGE      TENDER      MASS

<b>*Lymphatic</b>	<input type="checkbox"/> All Normal Findings	<b>Neck Nodes:</b> <b>NORMAL</b> <b>ABNORMAL</b> <b>Axillary Nodes:</b> <b>NORMAL</b> <b>ABNORMAL</b>
<b>*Respiratory</b>	<input type="checkbox"/> All Normal Findings	<b>Respiratory Effort:</b> <b>NORMAL</b> <b>ABNORMAL</b> <b>Auscultation:</b> <b>CLEAR</b> <b>ABNORMAL</b>
<b>*Cardiac</b>	<input type="checkbox"/> All Normal Findings	<b>Carotid Artery Pulses:</b> <b>NORMAL</b> <b>ABNORMAL</b> <b>Murmurs:</b> <b>YES</b> <b>NO</b> <b>Auscultation:</b> <b>REGULAR RATE AND RHYTHM</b> <b>ABNORMAL</b>
<b>*Neuro/*Psych</b>	<input type="checkbox"/> All Normal Findings	<b>Cranial Nerves:</b> <b>GROSSLY INTACT</b> <b>ABNORMAL</b> <b>Orientation:</b> <input type="checkbox"/> <b>ALERT AND ORIENTED TO PERSON/PLACE/ TIME</b> <b>ABNORMAL</b> <b>Mood &amp; Affect:</b> <b>GROSSLY NORMAL</b> <b>ABNORMAL</b>
<b>*GI/GU</b>	<input type="checkbox"/> All Normal Findings	Not assessed
<b>*Skin</b>	<input type="checkbox"/> All Normal Findings	Not assessed
<b>*Musculoskeletal</b>	<input type="checkbox"/> All Normal Findings	<b>AGE APPROPRIATE NORMAL GAIT AND STATION</b> Not assessed
<b>Extremities</b>	<input type="checkbox"/> All Normal Findings	Not assessed

Radiology films personally reviewed and discussed with patient/family: **YES**    **NO**

Outside medical records reviewed: **YES**    **NO**

Audiogram:    **YES**    Findings:  
**NO**

Assessment:

Plan:

- TREATMENT OPTIONS DISCUSSED**
- RISKS, BENEFITS, AND ALTERNATIVES DISCUSSED AND ALL QUESTIONS ANSWERED**
- FOLLOW UP IN** \_\_\_\_\_
- FURTHER TESTING**
- INFORMATION PACKET GIVEN TO PATIENT**

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Scott Rickert MD  
Acting Director of Pediatric Otolaryngology  
New York University Langone Medical Center  
160 East 32<sup>nd</sup> Street, L3 Medical  
New York, NY 10016  
212-263-0922 (o) / 646-501-5298 (f)