Patient Name: ____________________ PCP: ____________ Date: ____/____/____

Pediatric Initial Visit (p. 1): Please provide the following medical information to the best of your ability:

Age: | **DOB:** ____/____/____ | **List any ALLERGIES TO MEDICATIONS:**

What problems are you here for today?

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if the patient has any of the following illnesses; for "Yes" answers, please explain

	Yes	No			Yes	No	
Premature birth	☐	☐		Allergy problems/therapy	☐	☐	
Complication during pregnancy	☐	☐		Neurological problems	☐	☐	
Significant injuries	☐	☐		Ear problems	☐	☐	
Asthma / lung problems	☐	☐		Immune deficiency	☐	☐	
Heart problems	☐	☐		Are immunizations up to date	☐	☐	
Stomach or intestinal problems	☐	☐		Bleeding problems	☐	☐	
Kidney problems	☐	☐		Skin problems	☐	☐	
				Other Medical Diagnosis	☐	☐	

2) **Please list any operations (and dates) the patient has ever had *(including tonsils & adenoids)*:**

3) **Please list any current medications on the enclosed green Patient Medication List**

4) **Please list your child's favorite foods:** ____________________

4) **Please indicate any special therapy:** ☐ PT ☐ OT ☐ Speech ☐ Other ____________

Social History:

	Yes	No	Please list details below:
Does child attend day care?	☐	☐	
Are there pets in the house?	☐	☐	Describe
Is there smoke exposure?	☐	☐	Tobacco? Yes / No Wood? Yes / No How much?

Child's primary residence? ____________ **Secondary or other residence?** ____________

School grade? ____________ **Describe any special schools or classes** ____________

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses:

If yes, please indicate which relative(s) have the problem

	Yes	No			Yes	No	
Hearing or balance problems	☐	☐		Asthma / lung	☐	☐	
Allergy / Sinus	☐	☐		Heart Problems / Hypertension	☐	☐	
Diabetes	☐	☐		Headaches	☐	☐	
Cancer	☐	☐		High blood pressure	☐	☐	
Bleeding disorders	☐	☐		Other health problems	☐	☐	

☐ **See attached dictation** | **Reviewed by:**

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Patient Name:____ Date:____/____/____

Pediatric Initial Visit (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1) Please check the "Yes" or "No" box to indicate whether the patient presently has any of the following symptoms:
2) For any "yes" responses, please check the "current" box if this symptom relates to the reason for the visit today

		Yes	No	Current		Yes	No	Current
GENERAL	fever or chills	☐	☐	☐	weight loss or gain	☐	☐	☐
	fatigue	☐	☐	☐	daytime sleepiness	☐	☐	☐
ALLERGY	sneezing	☐	☐	☐	post-nasal drip	☐	☐	☐
	seasonal allergy	☐	☐	☐	food allergies	☐	☐	☐
NEURO	headache	☐	☐	☐	weakness	☐	☐	☐
	passing out / seizure	☐	☐	☐	numbness, tingling	☐	☐	☐
EYES	eye pain / pressure	☐	☐	☐	vision changes	☐	☐	☐
	watery or itchy eyes	☐	☐	☐				
ENT	ear pain or itch	☐	☐	☐	ear drainage	☐	☐	☐
	hearing loss	☐	☐	☐	ear noises	☐	☐	☐
	recurrent ear infections	☐	☐	☐	swelling neck or face	☐	☐	☐
	ear pressure / fullness	☐	☐	☐	lightheadedness	☐	☐	☐
	dizziness, vertigo	☐	☐	☐	mouth breathing	☐	☐	☐
	nasal congestion	☐	☐	☐	bad breath	☐	☐	☐
	nose bleeds	☐	☐	☐	sinus pressure or pain	☐	☐	☐
	recurrent "sinus infecs"	☐	☐	☐	discolored nasal dischg	☐	☐	☐
	recurrent throat infecs	☐	☐	☐	snoring with pauses	☐	☐	☐
	hoarseness	☐	☐	☐	throat pain	☐	☐	☐
	throat clearing	☐	☐	☐	throat dryness/itching	☐	☐	☐
RESPIR.	cough	☐	☐	☐	coughing blood	☐	☐	☐
	wheezing	☐	☐	☐	shortness of breath	☐	☐	☐
CARDIAC	chest pain	☐	☐	☐	palpitations	☐	☐	☐
	wake short of breath	☐	☐	☐	ankle swelling	☐	☐	☐
GI	difficulty swallowing	☐	☐	☐	heartburn	☐	☐	☐
	abdominal pain	☐	☐	☐	nausea/vomiting	☐	☐	☐
	bowel irregularity	☐	☐	☐	rectal bleeding	☐	☐	☐
GU	frequent urination	☐	☐	☐	painful urination	☐	☐	☐
	bladder infections	☐	☐	☐	kidney problems	☐	☐	☐
HEME/LYM	swollen glands	☐	☐	☐	sweating at night	☐	☐	☐
	bleeding problems	☐	☐	☐	easy bruising	☐	☐	☐
ENDO	feel warmer than others	☐	☐	☐	feel cooler than others	☐	☐	☐
	increased thirst	☐	☐	☐	increased urination	☐	☐	☐
MSK	joint aches	☐	☐	☐	muscle aches	☐	☐	☐
SKIN	rash	☐	☐	☐	itching	☐	☐	☐
	hives	☐	☐	☐	skin or hair changes	☐	☐	☐
PSYCH	depression	☐	☐	☐	anxiety or panic	☐	☐	☐

☐ See attached dictation

Reviewed by:

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Patient States Consultation Requested By____________________________

Patient Name:____ **Date:** ____/____/____

PRESENT ILLNESS Chronology w: 1. one to three elements [level 2] 2. four to eight elements; OR status of 3 chronic or inactive conditions [level 3, 4 or 5]

(1) duration (2) timing (3) severity; (4) location (5) quality (6) context (7) modifying factors (8) assoc. signs & symptoms

Nurse Hx:

Clinician Hx: ☐ See attached dictation

PHYSICAL EXAMINATION: Ear Nose & Throat

GENERAL (at least 3 measurements of vital signs) HT___ft___in WT_______lbs

BP sitting-standing ____/____mm Hg RESP _____/min TEMP ______o (F-C)

PULSE _____/min regular - irregular

			Normal	AB
	GENERAL APPEARANCE	Stature, nutrition	☐	☐
	COMMUNICATION & VOICE	Pitch, clarity	☐	☐
HEAD/ FACE	INSPECTION	Lesions, masses	☐	☐
	PALPATION / PERCUSSION	Skeleton, sinuses	☐	☐
	SALIVARY GLANDS	Masses, tenderness	☐	☐
	FACIAL STRENGTH	Symmetry	☐	☐
ENT	PNEUMO-OTOSCOPY	EACs; TMs mobile	☐	☐
	HEARING ASSESSMENT	Gross; Weber/Rinne	☐	☐
	EXTERNAL EAR & NOSE	Appearance	☐	☐
	INTERNAL NOSE	Mucosa, turbinates	☐	☐
	*AFTER DECONGESTANT	Septum, OMCs	☐	☐
	LIPS,TEETH & GUMS	Mucosa, tongue, dentition	☐	☐
	ORAL CAVITY, OROPHARYNX	Mucosa, tonsils, palate	☐	☐
	HYPOPHARYNX	Mucosa, pyriforms N/A	☐	☐
	LARYNX (mirror)	Anatomy, vc mobility N/A	☐	☐
	NASOPHAR. (mirror)	Mucosa, choanae N/A	☐	☐

			Normal	AB
NECK	MASSES & TRACHEA	Symmetry, masses	☐	☐
	THYROID	Size, nodules	☐	☐
EYES	OCULAR MOTILITY & GAZE	EOMs, nystagmus	☐	☐
RESP.	RESPIRATORY EFFORT	Inspiratory-expiratory	☐	☐
	AUSCULTATION	Lung sounds	☐	☐
CVS	HEART AUSCULTATION	rhythm, heart sounds	☐	☐
	PERIPH VASC SYSTEM	Edema, color	☐	☐
LYMPH.	NECK/AXILLAE/GROIN/ETC.	Adenopathy	☐	☐
NEURO/ PSYCH.	CRANIAL NERVES	II - XII	☐	☐
	ORIENTATION	Person, place, time	☐	☐
	MOOD & AFFECT	Comments	☐	☐
	*ROMBERG		☐	☐
	*TANDEM ROMBERG		☐	☐
	*PAST POINTING		☐	☐

☐ Procedure__________________________________ dictation / note

☐ See attached dictation

1. problem focused = 1-5 elements [level 1] 2. expanded = 6-11 elements [level 2] 3. detailed = 12 or more elements [level 3]
4. comprehensive = document every element in basic areas AND at least 1 element in each optional area [level 4 or 5] *optional

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Patient Name:____ **Date:** ____/____/____

MEDICAL DECISION MAKING
DATA REVIEWED (a):

2 of the 3 sections (a vs a' vs a'', b vs b', c vs c' vs c'') must meet or exceed indicated level of care
1. Minimal (level 2) 2. Limited (level 3) 3. Moderate (level 4) 4. Extensive (level 5)

Imaging: **Spirometry:** ☐ **See attached dictation**

Outside Records: **Allergy tests:**

Audio / Tympanogram **Lab/blood work:**

Other:

IMPRESSIONS / DIFFERENTIAL DIAGNOSES (b): **PLANS / MANAGEMENT OPTIONS (b')**

1. Minimal (level 2) 2. Limited (level 3) 3. Multiple (level 4) 4. Extensive (level 5)

☐ **See attached dictation**

RTC:________________ ☐ **Consultation with:**__________________

DATA ORDERED (a'): 1. Minimal or none (level 2) 2. Limited (level 3) 3. Moderate (level 4) 4. Extensive (level 5)

☐ Audiological ☐ Lab ☐ CT / MRI ☐ Other

☐ Allergy Test ☐ IDT ☐ Prick Test ☐ Basic Panel ☐ Farm / Mold / Tree Panel

Test Indications:____ ☐ Spirometry prior to test **Diagnosis:**________________

RISKS DISCUSSED: ☐ Anaphylaxis ☐ Beta Blocker ☐ Bleeding ☐ Unstable Asthma

☐ Other ____ ☐ **See attached dictation**

Information Sheets Given: Ear Care, Allergy Management, Antibiotic / Acidophilus, Indoor Air, Nasal Saline, Nose Care, URI info, Childhood Airway Obstrct, GERD, Pre / post op

COMPLEXITY OF DATA REVIEWED OR ORDERED (a'')

1. Minimal (level 2) 2. Limited (level 3) 3. Moderate (level 4) 4. Extensive (level 5)

1. min 2. limited 3. mod 4. extensive

RISK OF COMPLICATIONS &/OR MORBIDITY OR MORTALITY (see examples in Table of Risk)

1. Minimal (level 2) 2. Low (level 3) 3. Moderate (level 4) 4. High (level 5)

risk of presenting problem(s) (c):	1. min	2. low	3. mod	4. high
risk of diagnostic procedure(s) ordered or reviewed (c'):	1. min	2. low	3. mod	4. high
risk of management option(s) selected (c''):	1. min	2. low	3. mod	4. high

NATURE OF PRESENTING PROBLEM(S)

1. minor	(level 1)	Problem runs definite and prescribed course, is transient in nature, and is not likely to permanently alter health status; OR, has a good prognosis with management and compliance.
2. low	(level 1)	Problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.
3.low - mod	(level 2)	Problem where the risk of morbidity without treatment is low to moderate; there is low to moderate risk of mortality without treatment; full recovery without functional impairment is expected in most cases, with low probability of prolonged functional impairment
4. moderate	(level 3)	Problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; prognosis is uncertain, or there is an increased probability of prolonged functional impairment.
5. mod - high (l	(level 4,5)	Problem where the risk of morbidity without treatment is moderate to high; there is moderate risk of mortality without treatment; uncertain prognosis or increased probability of prolonged functional impairment
6. high	(level 4,5)	Problem where the risk of morbidity without treatment is high to extreme; there is moderate to high risk of mortality without treatment, or high probability of severe prolonged functional impairment.

Complete this section only if documented below >50% of visit time involved counseling and/or coordinating care.

TIME: _____________ minutes ☐ > 50% of visit time involved counseling and/or coordination of care

Clinician's signature:

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Patient Name:____________________________ **PCP:**_________________ **DOB:**____/____/____

Environment Review: Please complete details of all the sections that apply to you

	Yes	No
Do you live in the city?	☐	☐
Do you live in the country?	☐	☐
Do you live on a farm?	☐	☐
Do you have trees and/or lawn?	☐	☐
Do you live in a house:	☐	☐
Age of house, years leved there	_______ / _______	
Do you live in an apartment/condo'	☐	☐
Age and years leved there	_______ / _______	
Do you live in a mobile home?	☐	☐
Age and years leved there	_______ / _______	
Do you have a basement/crawl space	☐	☐
Is it wet or dry?	____________	
Do you have carpeting?	☐	☐
Age and amount?	____________	
Have you remodeled lately?	☐	☐
Do yo9u have indoor plants?	☐	☐
Are there smokers in your home, apartment, or condo?	☐	☐
Do you have a hepa filter?	☐	☐
What type of heating system?	____________	
What type of cooling system?	____________	

	Yes	No	
Do you work outdoors?	☐	☐	
Do you work indoors?	☐	☐	
Do you have increased symptoms at school or work?	☐	☐	
List any school or work related allergy/sinus symptoms	____________		
Do you use a mask when you clean, mow, or sweep?	☐	☐	
Do you have feather pillows?	☐	☐	
Do you have down comforters?	☐	☐	
Do you use pillow/mattress covers'	☐	☐	
Do you have frequent exposure to:			(if yes, circle:)
Dog	☐	☐	Inside or Outside
Cat	☐	☐	Inside or Outside
Bird	☐	☐	Inside or Outside
Rodents	☐	☐	Inside or Outside
Livestock	☐	☐	
Other (list)	☐	☐	Inside or Outside

PLEASE STOP HERE ☐ **See attached dictation**

Reviewed by:

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