

# Nose, Mouth, Throat, Ears, and Hearing

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

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## History

### *Review of History Related to Nose, Mouth, Throat, and Ears:*

YES/NO	If YES, provide details:
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#### **Nose**

- |                          |                          |                                    |       |
|--------------------------|--------------------------|------------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Problem with your nose             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma/surgery to nose             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Problem with your sinuses          | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (ask about presentation) | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury of or surgery on nose       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in smell ability            | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal obstruction                  | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold and/or sneezing               | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Snorting or sniffing substances    | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Snoring                            | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds                         | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus infection                    | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of nasal sprays                | _____ |
|                          |                          | <i>Type spray:</i>                 | _____ |
|                          |                          | <i>Length of use:</i>              | _____ |

#### **Mouth**

- |                          |                          |                           |             |
|--------------------------|--------------------------|---------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Problem with your mouth   | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Lesions or sores in mouth | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen or bleeding gums  | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Problem with your teeth   | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty chewing        | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Lost teeth                | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Wear dentures (fit)       | _____       |
| <input type="checkbox"/> | <input type="checkbox"/> | Last dental check-up      | Date: _____ |

- Change in taste \_\_\_\_\_
- Sensitivity to cold or hot \_\_\_\_\_
- Bad breath \_\_\_\_\_
- Painful tongue \_\_\_\_\_
- Tongue, mouth, lip piercing \_\_\_\_\_

**Throat**

- Hoarseness \_\_\_\_\_
- Loss of voice \_\_\_\_\_
- Difficulty swallowing \_\_\_\_\_
- Frequent sore throats \_\_\_\_\_
- Frequent infections \_\_\_\_\_

**Tobacco Products**

- Smoke cigarettes \_\_\_\_\_
- Smoke pipe \_\_\_\_\_
- Chew tobacco \_\_\_\_\_
- Related problems \_\_\_\_\_

**Ears and Hearing**

- Ear disease or trauma \_\_\_\_\_
- Tinnitus \_\_\_\_\_
- Dizziness or Vertigo \_\_\_\_\_
- Medications \_\_\_\_\_
- Occupational Noise Exposure \_\_\_\_\_
- Discharge from Ears \_\_\_\_\_
- Infections \_\_\_\_\_
- Otagia \_\_\_\_\_
- Allergies \_\_\_\_\_
- Hearing Problems \_\_\_\_\_

If Yes: One or both ears Onset  
 Best sounds heard Difficult sounds heard  
 Speech How managed

- Hearing Aid Use \_\_\_\_\_

**Current medications:** \_\_\_\_\_

**Family history of nose, mouth, throat, ears, or hearing problems:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Health promotion/specific prevention behaviors related to mouth, nose, throat, ears or hearing:**

## Current Problem

**Focused symptom analysis of current problem:**

**Character:** \_\_\_\_\_

**Onset:** \_\_\_\_\_

**Duration:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Severity:** \_\_\_\_\_

**Associated problems:** \_\_\_\_\_

**Efforts to treat:** \_\_\_\_\_

## Physical Assessment Inspect and Palpate.

### **Nose:**

**Appearance** (symmetry, placement, lesions, scars): \_\_\_\_\_  
\_\_\_\_\_

**Nasal Discharge** (amount, characteristics, odor): \_\_\_\_\_  
\_\_\_\_\_

**Nasal Patency** (air movement, bilateral patency, septum position and character): \_\_\_\_\_  
\_\_\_\_\_

**Olfactory nerve** (CN 1 – smell, test bilaterally): \_\_\_\_\_

**Sinus tenderness** (inspect and palpate sinuses): \_\_\_\_\_  
\_\_\_\_\_

### **Mouth:**

**General characteristics** (hygiene, teeth, lips, smile, ease of movement): \_\_\_\_\_  
\_\_\_\_\_

**Teeth** (number, repair, alignment, hygiene, placement/stability, tenderness): \_\_\_\_\_  
\_\_\_\_\_

**Gums** (lesions, color, bleeding, swelling): \_\_\_\_\_

**Hard and soft palate** (color, pigmentation, moisture, lesions): \_\_\_\_\_  
\_\_\_\_\_

**Mucous membrane** (color, pigmentation, moisture, salivary glands): \_\_\_\_\_  
\_\_\_\_\_

**Tongue** (color, position, exudate, lumps, masses): \_\_\_\_\_  
\_\_\_\_\_

**Throat:**

**General characteristics** (swallowing, lesions): \_\_\_\_\_  
\_\_\_\_\_

**Posterior pharynx** (color, swelling, exudate, tonsils, tonsillar pillar, uvula): \_\_\_\_\_  
\_\_\_\_\_

**Glossopharyngeal and vagus nerves** (CN – IX and CN – X; movement of uvula, soft palate, and gag reflex): \_\_\_\_\_

**Ears and Hearing:**

**Inspect and palpate.**

**Skin of ears** (color, tone, and texture): \_\_\_\_\_

**Auricles** (position and shape, lesions): \_\_\_\_\_

**Auditory meatus** (patency, drainage): \_\_\_\_\_

**Ear alignment with eyes:** \_\_\_\_\_

**Pinna, tragus** (characteristics, position): \_\_\_\_\_

**Mastoid process:** \_\_\_\_\_

**Drainage, inflammation, tenderness, lesions:** \_\_\_\_\_

**Otoscopic examination:**

**Ear canal** (color, characteristics, cerumen, lesions, foreign objects, drainage): \_\_\_\_\_

\_\_\_\_\_

**Tympanic membrane** (color, intactness, landmarks, characteristics): \_\_\_\_\_

\_\_\_\_\_

**Hearing acuity:**

**Watch or whisper** (sound characteristics):  **Expected**  **CD Unexpected**

**Describe:** \_\_\_\_\_

**Rinne test** (air conduction > bone conduction):  **Expected**  **CD Unexpected**

**Describe:** \_\_\_\_\_

**Weber test** (sound lateralization):  **Expected**  **CD Unexpected**

**Describe:** \_\_\_\_\_

**Romberg test** (balance maintained):  **Yes**  **No**

**Describe:** \_\_\_\_\_

**Analysis:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_