Illinois Department of Public Health

TREATING PHYSICIAN'S REPORT

Name	Date of Birth / /	Screening Program
Parent's Name		Screening Location
Street Address		Referred By
City	County	

EAR EXAMINATION

AUDITORY CANAL

R L
☐ ☐ NO FINDINGS
☐ ☐ FINDINGS →

OCCLUDED

R L
☐ ☐ PARTIALLY
☐ ☐ COMPLETELY

OCCLUDED BY

R L
☐ ☐ CERUMEN
☐ ☐ FOREIGN BODY

R L
☐ ☐ INFLAMMATION
☐ ☐ OTHER (DESCRIBE)

DRUM

R L
☐ ☐ NO FINDINGS
☐ ☐ FINDINGS →
☐ ☐ NOT VISIBLE

R L
☐ ☐ DULL
☐ ☐ BULGING
☐ ☐ RETRACTED
☐ ☐ PERFORATED

R L
☐ ☐ SCARS
☐ ☐ OPAQUE
☐ ☐ RED
☐ ☐ OTHER (DESCRIBE)

NOSE AND THROAT EXAMINATION

TONSILS

☐ REMOVED COMPLETELY
☐ TONSILS PRESENT (NORMAL)
☐ TONSILS PRESENT (ENLARGED)

ORAL PHARYNX

☐ NO FINDINGS
☐ CLEFT PALATE
☐ REPAIRED ☐ UNREPAIRED

☐ POSTNASAL DISCHARGE
☐ MOUTH BREATHING
☐ OTHER (DESCRIBE)

DIAGNOSIS

☐ CANAL OBSTRUCTIONS
☐ SEROUS OTITIS MEDIA
☐ DRUM PERFORATION
☐ ALLERGIES
☐ OTHER (DESCRIBE) ____________________

☐ CONDUCTIVE HEARING LOSS
☐ SENSORI-NEURAL HEARING LOSS
☐ CONFIRMED BY BONE CONDUCTION AUDIOMETRY
☐ CONFIRMED BY TUNING FORK
☐ MIXED HEARING LOSS
☐ OTHER (DESCRIBE) ____________________

COMMENTS

TREATMENT

I SUGGEST A REPEAT AUDIOGRAM IN ________ WEEKS.

RELEASE OF INFORMATION

CONSENT OF PARENT OR GUARDIAN
I agree to release the above information on my child or ward to appropriate health and/or school authorities.

SIGNATURE OF PARENT OR GUARDIAN

Date of Examination / /

Stamp or Print Physician's Name

Address

IL 482-0838

PLEASE RETURN THIS FORM TO ____________________
NAME OF SCHOOL