

Nurse Specialist Laryngoscopy Clinic



Soon Routine Urgent

History

Symptoms	Yes	No	Social History	Yes	No
Dysphonia:	___	___	Smoker:	___	___
Dysphagia:	___	___	If yes, how many for how long?	_____	
Weight loss:	___	___	Alcohol:	___	___
Acid reflux:	___	___	If yes, how many units per week?	_____	

Medication (please list)

Laryngoscopy

Nostril Rt L

Nasopharynx Any abnormalities seen.

Base of Tongue Any abnormalities seen.

Hypopharynx Any abnormalities seen.

Larynx	Rt Cord		Lt Cord
	Yes ___ No ___	Smooth	Yes ___ No ___
	Yes ___ No ___	Irregular	Yes ___ No ___
	Yes ___ No ___	Movement	Yes ___ No ___

Review by Consultant or ENT Specialist

MWY _____

MAS _____

AWH _____

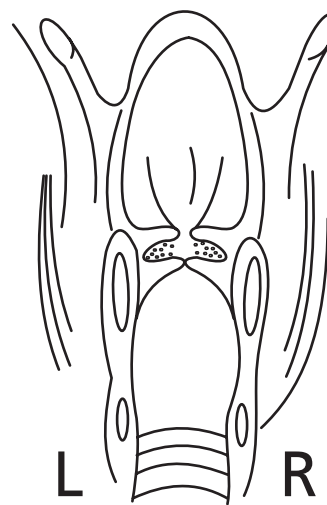
Other _____

Verification or Other Findings on Examination

Further Investigations/Treatment Required

Further Review Date

Record of Findings



Date: _____

Signature: _____

Stamp