

UPPER AIRWAY EXAMINATION FORM



Date: _____ Clinician: _____

After induction: place in sternal recumbency, sling maxilla with gauze tape behind the canine teeth, no head tilt and no pressure on the ventral neck area.

Anesthesia induction agent: _____ Doxapram?: Yes If yes, _____ mg/kg No

**Decreased TMJ ROM?: No Yes

Abduction on inspiration:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> None <input type="checkbox"/> Paradoxical <input type="checkbox"/> Asynchronous Right: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> None <input type="checkbox"/> Paradoxical <input type="checkbox"/> Asynchronous
Laryngeal sensitivity:	<input type="checkbox"/> Normal adduction <input type="checkbox"/> Decreased adduction <input type="checkbox"/> Absent Fasciculations? <input type="checkbox"/> R <input type="checkbox"/> L
Palate sensitivity:	<input type="checkbox"/> Normal gag <input type="checkbox"/> Decreased gag <input type="checkbox"/> Absent
Nares:	<input type="checkbox"/> Normal <input type="checkbox"/> Patent Y <input type="checkbox"/> N <input type="checkbox"/> Stenotic Other: _____
Tongue:	<input type="checkbox"/> Normal <input type="checkbox"/> Large Other: _____
Hard palate:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Soft palate:	<input type="checkbox"/> Normal <input type="checkbox"/> Long _____ mm <input type="checkbox"/> Short _____ mm <input type="checkbox"/> Thickened Cleft: _____ Other: _____
Tonsils:	<input type="checkbox"/> Normal <input type="checkbox"/> Enlarged <input type="checkbox"/> Out of crypt <input type="checkbox"/> In crypt Other: _____
Pharynx:	Left wall: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Right wall: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Dorsal wall: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Epiglottis:	Shape: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Mucosal surfaces: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Hyoepiglottis: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Retroversion?: <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____
Piriform recess:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Partially obliterated <input type="checkbox"/> Fully obliterated Right: <input type="checkbox"/> Normal <input type="checkbox"/> Partially obliterated <input type="checkbox"/> Fully obliterated
Laryngeal mucosa:	<input type="checkbox"/> Normal <input type="checkbox"/> XS phlegm <input type="checkbox"/> Hyperemic <input type="checkbox"/> Ulcerated <input type="checkbox"/> Swollen <input type="checkbox"/> Redundant
Cuneiforms:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Thickened <input type="checkbox"/> Medially displaced <input type="checkbox"/> Overlapping <input type="checkbox"/> Cannot visualize Right: <input type="checkbox"/> Normal <input type="checkbox"/> Thickened <input type="checkbox"/> Medially displaced <input type="checkbox"/> Overlapping <input type="checkbox"/> Cannot visualize
Corniculates:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Thickened <input type="checkbox"/> Medially displaced <input type="checkbox"/> Overlapping <input type="checkbox"/> Cannot visualize Right: <input type="checkbox"/> Normal <input type="checkbox"/> Thickened <input type="checkbox"/> Medially displaced <input type="checkbox"/> Overlapping <input type="checkbox"/> Cannot visualize
Ventricles:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Sub-effaced <input type="checkbox"/> Effaced <input type="checkbox"/> Partially everted <input type="checkbox"/> Fully everted Right: <input type="checkbox"/> Normal <input type="checkbox"/> Sub-effaced <input type="checkbox"/> Effaced <input type="checkbox"/> Partially everted <input type="checkbox"/> Fully everted
Vocal folds:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Hyperemic <input type="checkbox"/> Swollen <input type="checkbox"/> Nodule/cyst <input type="checkbox"/> Cannot visualize Right: <input type="checkbox"/> Normal <input type="checkbox"/> Hyperemic <input type="checkbox"/> Swollen <input type="checkbox"/> Nodule/cyst <input type="checkbox"/> Cannot visualize Other: _____
Rima glottidis:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____
Webbing:	<input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Dorsal <input type="checkbox"/> Ventral

FLEXIBLE ENDOSCOPE: O

CT: O

Infraglottic lumen:	<input type="checkbox"/> Normal <input type="checkbox"/> Keyhole Other: _____
Nasopharynx & choanae:	<input type="checkbox"/> Normal <input type="checkbox"/> CAT Other: _____
Trachea:	<input type="checkbox"/> Normal <input type="checkbox"/> Cough elicited <input type="checkbox"/> Hyperemic <input type="checkbox"/> XS phlegm <input type="checkbox"/> Collapse: grade: _____ <input type="checkbox"/> Inverted rings <input type="checkbox"/> Hypoplastic Other: _____
Mainstem bronchi:	Left: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Right: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____

Otic Examination:	Left: _____ Right: _____
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