## Form 1A
### OMT in Management of Recurrent Otitis Media

**Chart Review**

Fax completed forms to (918) 747-9778

**Patient Identification**

<table>
<thead>
<tr>
<th>First Year of Life</th>
<th>D.O.B.</th>
<th>Head Circumference at Birth</th>
</tr>
</thead>
</table>

| Dates of Ear Checks | 0 | 2 | 4 | 6 | 8 | 10 | 12 | 14 | 16 | 18 | 20 | 22 | 24 | 26 | 28 | 30 | 32 | 34 | 36 | 38 | 40 | 42 | 44 | 46 | 48 |
|---------------------|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

**Symptomology (Wks):**

<table>
<thead>
<tr>
<th>Lt. Side: TM Red, Vel.</th>
<th>Fluid</th>
<th>Clear</th>
<th>Ear Pain</th>
<th>Injury, Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rt. Side: TM Red, Vel.</th>
<th>Fluid</th>
<th>Clear</th>
<th>Ear Pain</th>
<th>Injury, Fall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Serious Medical Problems or Surgery (Date & Describe):**

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## OMT IN MANAGEMENT OF RECURRENT OTITIS MEDIA

**Chart Review**

### Fax Completed Forms to (918) 747-9778

### Patient Identification

#### Second Year of Life

<table>
<thead>
<tr>
<th>Dates of Ear Checks</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>12</th>
<th>14</th>
<th>16</th>
<th>18</th>
<th>20</th>
<th>22</th>
<th>24</th>
<th>26</th>
<th>28</th>
<th>30</th>
<th>32</th>
<th>34</th>
<th>36</th>
<th>38</th>
<th>40</th>
<th>42</th>
<th>44</th>
<th>46</th>
<th>48</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Symptomology (Wks)</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>12</th>
<th>14</th>
<th>16</th>
<th>18</th>
<th>20</th>
<th>22</th>
<th>24</th>
<th>26</th>
<th>28</th>
<th>30</th>
<th>32</th>
<th>34</th>
<th>36</th>
<th>38</th>
<th>40</th>
<th>42</th>
<th>44</th>
<th>46</th>
<th>48</th>
</tr>
</thead>
</table>

**Lt Side:** TM Red, Yel.

- Fluid
- Clear

**Ear Pain**

**Injury, Fall**

**Rt Side:** TM Red, Yel.

- Fluid
- Clear

**Ear Pain**

**Injury, Fall**

**Fever**

**Upper Resp. Sx**

**Lower Resp. Sx**

**Irritability**

**Antibiotic**

**Antihistamine**

**Decongestant**

**Steroid/ Bronchodilator**

**Tubes or other ENT Surgery**

### Other Serious Medical Problems or Surgery (Date & Describe):

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________
# FORM 1A  OMT IN MANAGEMENT OF RECURRENT OTITIS MEDIA

**Chart Review**

Fax completed forms to (918) 747-9778

### Third Year of Life

<table>
<thead>
<tr>
<th>Dates of Ear Checks</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Symptomology (Wks)**

| LT Side: TM Red, Yel | 0 | 2 | 4 | 6 | 8 | 10 | 12 | 14 | 16 | 18 | 20 | 22 | 24 | 26 | 28 | 30 | 32 | 34 | 36 | 38 | 40 | 42 | 44 | 46 | 48 |
|----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

- Fluid
- Clear
- Ear Pain
- Injury, Fall

**RT Side: TM Red, Yel**

- Fluid
- Clear
- Ear Pain
- Injury, Fall

- Febrile
- Upper Resp. Sx
- Lower Resp. Sx.
- Irritability
- Antibiotic
- Antihistamine
- Decongestant
- Steroid/Bronchodilator
- Tubes or other ENT Surgery

**Other Serious Medical Problems or Surgery (Date & Describe):**

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**FORM 1A**

**OMT IN MANAGEMENT OF RECURRENT OTITIS MEDIA**

**CHART REVIEW**

**FAX COMPLETED FORMS TO (918) 747-9778**

**PATIENT IDENTIFICATION □□□□**

**FOURTH YEAR OF LIFE**

<table>
<thead>
<tr>
<th>DATES OF EAR CHECKS</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>12</th>
<th>14</th>
<th>16</th>
<th>18</th>
<th>20</th>
<th>22</th>
<th>24</th>
<th>26</th>
<th>28</th>
<th>30</th>
<th>32</th>
<th>34</th>
<th>36</th>
<th>38</th>
<th>40</th>
<th>42</th>
<th>44</th>
<th>46</th>
<th>48</th>
</tr>
</thead>
</table>

**SYMPTOMOLOGY (WKS)**

<table>
<thead>
<tr>
<th>LT SIDE: TM RED, YEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLUID</td>
</tr>
<tr>
<td>CLEAR</td>
</tr>
<tr>
<td>EAR PAIN</td>
</tr>
<tr>
<td>INJURY, FALL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RT SIDE: TM RED, YEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLUID</td>
</tr>
<tr>
<td>CLEAR</td>
</tr>
<tr>
<td>EAR PAIN</td>
</tr>
<tr>
<td>INJURY, FALL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEBRILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>UPPER RESP. SX</td>
</tr>
<tr>
<td>LOWER RESP. SX</td>
</tr>
<tr>
<td>IRRITABILITY</td>
</tr>
<tr>
<td>ANTIBIOTIC</td>
</tr>
<tr>
<td>ANTIHISTAMINE</td>
</tr>
<tr>
<td>DECONGESTANT</td>
</tr>
<tr>
<td>STEROID/BRONCHODILATOR</td>
</tr>
<tr>
<td>TUBES OR OTHER ENT SURGERY</td>
</tr>
</tbody>
</table>

**OTHER SERIOUS MEDICAL PROBLEMS OR SURGERY (DATE & DESCRIBE):**

__________________________________________________________________________________________
**Fifth Year of Life**

<table>
<thead>
<tr>
<th>Dates of Ear Checks</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
<th>12</th>
<th>14</th>
<th>16</th>
<th>18</th>
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<th>34</th>
<th>36</th>
<th>38</th>
<th>40</th>
<th>42</th>
<th>44</th>
<th>46</th>
<th>48</th>
</tr>
</thead>
</table>

**Symptomology (Wks)**

<table>
<thead>
<tr>
<th>Lt Side: TM Red, Yel.</th>
<th>FLUID</th>
<th>CLEAR</th>
<th>EAR PAIN</th>
<th>INJURY, FALL</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>RT Side: TM Red, Yel.</th>
<th>FLUID</th>
<th>CLEAR</th>
<th>EAR PAIN</th>
<th>INJURY, FALL</th>
</tr>
</thead>
</table>

- Febrile
- Upper Resp. Sx
- Lower Resp. Sx
- Irritability
- Antibiotic
- Antihistamine
- Decongestant
- Steroid/Bronchodilator
- Tubes or other ENT Surgery

Other serious medical problems or surgery (date & describe): 

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Fax completed forms to (918) 747-9778

Patient Identification: [ ] [ ] [ ] [ ]
| Dates of Ear Checks | 0  | 2  | 4  | 6  | 8  | 10 | 12 | 14 | 16 | 18 | 20 | 22 | 24 | 26 | 28 | 30 | 32 | 34 | 36 | 38 | 40 | 42 | 44 | 46 | 48 |
|---------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Symptomology (Wks)  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

**Lt Side:** TM Red, Yel
- Fluid
- Clear
- Ear Pain
- Injury, Fall

**Rt Side:** TM Red, Yel
- Fluid
- Clear
- Ear Pain
- Injury, Fall

- Fever
- Upper Resp. Sx.
- Lower Resp. Sx.
- Irritability
- Antibiotic
- Antihistamine
- Decongestant
- Steroid/ Bronchodilator
- Tubes or Other ENT Surgery

Other serious medical problems or surgery (Date & Describe):
# OMT in Management of Recurrent Otitis Media

**Chart Review**

Fax completed forms to (918) 747-9778

## Seventh Year of Life

| Dates of Ear Checks | 0 | 2 | 4 | 6 | 8 | 10 | 12 | 14 | 16 | 18 | 20 | 22 | 24 | 26 | 28 | 30 | 32 | 34 | 36 | 38 | 40 | 42 | 44 | 46 | 48 |
|---------------------|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|

### Symptomology (Wks)
- **LT Side:** TM Red, Yel
  - Fluid
  - Clear
  - Ear Pain
  - Injury, Fall
- **RT Side:** TM Red, Yel
  - Fluid
  - Clear
  - Ear Pain
  - Injury, Fall
- Febrile
- Upper Resp. Sx
- Lower Resp. Sx
- Irritability
- Antibiotic
- Antihistamine
- Decongestant
- Steroid/Bronchodilator
- Tubes or Other ENT Surgery

**Other Serious Medical Problems or Surgery (Date & Describe):**

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