Full Name_____ D.O.B.___/___/_____ Date: ___/___/_____

Acute respiratory Infection Visit *for* Colds, Bronchitis, Sore Throat, Earache or Sinusitis

(You may also complete this form online at www.yourhealthfile.com.)

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1. Indicate if you have any of the following symptoms: (check all that apply)

dry cough__ cough up yellow mucus__ cough up green mucus__ cough up clear mucus__

cough up bloody mucus__ clear mucus from nose__ yellow or green mucus from nose__ bloody

discharge from nose__ stuffy nose__ sinus congestion__ sore throat__ ear pain__ headache__

2. How bad are your symptoms? mild__ moderate__ severe__ improving__ getting worse__

3. How long have you had your current respiratory symptoms?

less than 24 hours__ 1 day__ 2 to 3 days__ 4 to 6 days__ 1 week__ 1 to 2 weeks__

about 2 to 3 weeks__ more than 3 weeks__ about a month__ 1 to 2 months__ more than 2 months__

4. Has any family member or close contact recently had symptoms similar to yours? Yes__ No__

5. Have you had a fever with your symptoms? Yes__ No__ **If yes, how high?** _____ degrees

6. Do you have any of these other associated symptoms? (check all that apply)

diarrhea__ nausea__ vomiting__ chills__ body aches__ wheezing__ chest hurts__

chest feels tight__ chest pain when coughing__ chest pain when taking a deep breath__ hoarseness__

short of breath__ swollen glands in the neck__ drenching sweats at night__ other_____

7. Have you ever had any of the following illnesses? (check all that apply)

sinus infection__ pneumonia__ bronchitis__ strep throat__ asthma __ hay fever__

heart disease __ COPD__ other lung disease__ postnasal drip __ nasal allergies __

8. Have you tried any over-the-counter medications to treat your symptoms? Yes__ No__
If yes what is name or type of medication(s)? _____

9. Have you recently taken any prescription medicine for this illness? Yes__ No__ **If yes, name all prescriptions:** _____

10. List any medications that have helped your symptoms so far._____

11. Have you recently seen another healthcare provider for this illness? Yes__ No__
If yes, what is the specialty of that provider? urgent care__ walk-in clinic__ primary care__
lung specialist__ allergist__ emergency room__ other type of healthcare provider__

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12. Which *best* describes the recent treatment for your acute respiratory symptoms?

I have not yet received treatment__ I have been treated recently but the treatment did not work__

I got better with treatment but symptoms have now come back__ I am receiving treatment now but

the treatment is not helping__ I am receiving treatment now and the treatment is helping__

13. How long has it been since your last chest x-ray?

less than a month__ 1 to 3 months__ 3 to 6 months__ 6 months to 1 year__ more than 1 year__

don't remember__ never had a chest x-ray before__

14. Do you currently smoke cigarettes? Yes__ No__

15. Have you had recent lab tests related to your symptoms? Yes__ No__ **If yes, what is name or type of test?** _____

16. Have the symptoms of acute respiratory infection caused you to be unable to perform your daily activities such as a job or housework? Yes__ No__

Medical History *(please complete if we have not seen you as a patient in the past month)*

***Check* if you're allergic to:** No allergies___ Penicillin____ Sulfa___ Aspirin___ Codeine___ Iodine___ Latex___ Cipro___ Macrodantin___ Bactrim___ Keflex___	**List all allergies to other drugs:**
Please give us an up to date list of names and dosages of all medicines you are taking:	
***Check* if you *have now or ever had* :** ___stroke[436] ___heart attack[412] ___ COPD[496] ___blocked arteries in your heart[41401] ___diabetes[25000] ___high blood pressure[4011] ___high cholesterol[2720] ___asthma[49390] ___underactive thyroid[2449] ___ kidney stones[5929] ___chronic kidney disease[5859] ___breast cancer[1749] ___prostate cancer[185] other cancer (what kind?):	
Have you ever had any other serious medical problems? No___ Yes___ If yes, please list:	
What surgeries have you had? heart bypass___ heart valve___ tonsils out___ gallbladder out___ appendix out___ uterus out___ kidney removed___ others (list them):	
Tobacco use: never used ___ quit smoking___ when? _____ still smoke, dip or chew___ **Alcohol use:** never used ___ ex-drinker___ occasional___ social___ light___ heavy___	
Ladies only: Is there a chance you could be pregnant? No___ Yes___ Not Sure___ When was your last period?_____	