UPPER/LOWER RESPIRATORY INFECTIONS

DATE: _____ **NAME:** _____ **DOB/AGE:** _____

S: **ALLERGIES:** _____ **WORK LOSS:** _____ **PREG:** _____

CURRENT RX: _____ **TOBACCO USE:** _____ **ASTHMA:** _____

HEADACHE FATIGUE MYALGIAS CHILLS/TEMP/SWEATS: _____ **DURATION:** _____

EYES: red disc ithc ears: _____ **EARS (R/L):** pain disch tubes hearing _____ **THROAT:** st glands laryngitis

NOSE: cong pressure PND disch/color _____ **CHEST:** pain cough productive Y/N color _____

SKIN/RASH: _____ **OTHER:** nausea vomit diarrhea pain _____

ADDITIONAL HX: _____

O: **VITALS:** BP: _____ P: _____ T: _____ Weight: _____ OTHER: _____

_____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____ Neck: _____ Lungs: _____

Heart: _____ Skin: _____

A: _____

P: _____

_____

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