Upper/Lower Respiratory Infections

Subjective Data								
Patient Name:			Date:		Age:			
Pregnant:	☐ Yes	☐ No/Unlikely		Asthma:	☐ Yes	☐ No		
Tobacco Use:	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never				
Alcohol Consumption:	☐ Daily	☐ Weekly	☐ Occasionally	☐ Never				
Allergies:								
Current Medication:								
Headaches:	☐ Yes	☐ No	Duration:					
Chills/Sweat:	☐ Yes	☐ No	Duration:					
Fatigue:	☐ Yes	☐ No	Duration:					
Myalgia:	☐ Yes	☐ No	Duration:					
Nausea:	☐ Yes	☐ No	Duration:					
Vomiting:	☐ Yes	☐ No	Duration:					
Chest Pains:	☐ Yes	☐ No	Symptoms:					
Throat Issues:	☐ Yes	☐ No	Symptoms:					
Nose Issues:	☐ Yes	☐ No	Symptoms:					
Eye Issues:	☐ Yes	☐ No	Symptoms:					
Ear Issues:	☐ Yes	☐ No	Symptoms:					
Other:	☐ Yes	☐ No	Symptoms:					
Objective Data								
Vitals	BP:		P:		T:			
	Weight:		Other:					
Eyes:		Ears:		Nose:		Skin:		
Neck:		Lungs:		Heart:		Throat:		
Assessment								
Plan for Treatment								

Signature _____ Date _____