

UPPER RESPIRATORY INFECTION EXAM



Name: _____ Age: _____ Date: _____

PATIENT SECTION

Please answer the following questions. This will help your physician identify possible problems.

Do you have a runny nose? Yes No

If "yes," describe the nature of drainage:

clear yellow/green white thick bloody

Do you have any nasal congestion? Yes No

Do you have any sinus pain? Yes No

Do you have post nasal drip? Yes No

Are your eyes: red? watery? itchy?

Do you have ear pain? Yes No

Do you have a fever? Yes No

Do you have nausea? Yes No

Have you vomited? Yes No

Do you have diarrhea? Yes No

Do you have a sore throat? Yes No

Are you achy? Yes No

Do you have any pain? Yes No

If "yes," rate your level of pain:

None 0 1 2 3 4 5 6 7 8 9 10 Severe

Do you have any rashes? Yes No

Do you have a cough? Yes No

If "yes," describe your cough: dry productive

Nature of sputum, if any:

clear yellow/green white thick bloody

Do you have asthma? Yes No

Do you use tobacco? Yes No

Other symptoms: _____

Do you have any allergies? _____

How long have you felt sick? _____

What medicines have you tried? (Include herbal or over-the-counter medicines.) _____

Was there any improvement? _____

Do you need a work note? Yes No

Do you need other medicine refilled? Yes No

PROVIDER SECTION

CC: _____

HPI: Patient history reviewed

EXAM: Well-developed/well-nourished; no acute distress

Vital signs: See flow sheet in chart

| | Normal | Abnormal | |
|---------|--------------------------|--------------------------|-------|
| ears | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| eyes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| nose | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| sinuses | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| pharynx | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| nodes | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| lungs | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| heart | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| abdomen | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| other | | | _____ |

ASSESSMENT

- Acute bronchitis 466.0
- Allergic rhinitis 477.9
- Asthma 493.90
- Conjunctivitis 372.00
- Flu 487.1
- Otitis externa 380.10
- Otitis media 382.9
- Otitis media, serous 381.10
- Pharyngitis 462
- Pneumonia 486
- Sinusitis 461.9
- Strep 034.0
- URI 465.9

PLAN:

- Strep test: (+), see antibiotics below (-), do culture and sensitivity
- Chest X-ray

Over-the-counter drugs:

Claritin Claritin D bid Sudafed prn Other: _____

Prescription drugs:

- Allegra: 60mg bid or 180mg/day
- Zyrtec: 10mg/day
- Phenergan VC with Codeine: 1-2 tsp q 4 hr
- Other: _____

Antibiotics:

- Amoxil: 250mg, 500mg or 200/5mL bid or tid
- Augmentin: 250mg, 500mg or 875mg bid or tid
- Erythromycin: 250mg, 333mg or 500mg bid or tid
- Zithromax Zithromax Tri-Pak Tessalon Perles 100mg qid
- Other: _____

Patient education? Yes No

Follow up: prn or _____ week(s) or _____ month(s)

Off work or school from _____ to _____

PHYSICIAN/PROVIDER SIGNATURE

DATE