URI

Name: ______________________________

Date: ______________________________ Time: __________

C.C.

S:

	Yes	No	Duration	Describe
Nasal Congestion				
Cough				
Non-Productive				
Productive				
Headache				
Facial Pain/Pressure				
Ear Pain				
Sore throat				
Fever				
HX of Asthma/ Bronchitis/ O.M.				

Allergies: Drug Allergies:

Medications presently taking: List:

Other History:

O: T ______ P ______ R ______ BP ______

Weight: __________ Height: __________

		Nor	Abn	Describe Abnorm
Eyes				
TMs	R			
	L			
Throat				
Lymph Nodes				
Lungs				
Sinus Palpation				
Nose				
Neck				
Other				
Quick Strep				Result:
Pulse Oximetry				Result:

A:

P:

Humidification	Decongestant	Rest	Hot/cold sinus tx
Acetaminophen	Increase fluids	Extra Vitamin C	Saline gargles
Ibuprofen	Zinc Lozenges		

Prescription or RX:

Yes	No	
		Recheck with Clinic if no improvement in 24-48 hours

Other Instructions:

Signature: ______________________________ Date: ______________

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