

Personal details

Name: _____ Surname: _____ Date: _____
Address: _____ suburb: _____ post code: _____
Ph (home): _____ Mobile: _____
Date of birth: _____ Age: _____ sex: F M Pregnant: Y N
Occupation: _____
Do you have any medical condition? Y N. If yes please specify.....

Any medications taken:

Medication	Reason

1. Are you allergic to any medications or food? Y N If yes please specify.....
2. Have you seen a GP for your current illness? Y N If yes what is the diagnosis?.....
3. How long since the beginning of your symptoms?days
4. Do you suffer from bacterial / viral infection / don't know? (Please circle) other.....
5. Do you have / had fever associated with your current symptoms? (Please circle if yes) Y N
6. Is your nose blocked? Y N
7. Do you have runny nose? Y N if yes is it thick / clear / other.....
8. Do you have sore sinuses? Y N
9. Are your glands (along the neck) swollen or sensitive? Y N
10. Have you been getting headaches with your current illness? Y N
11. Do you have sore throat? Y N. If yes is it dry/ irritated/ with phlegm (Please circle any) other....
12. Do you cough as a result of the infection? Y N if yes does it affect your night sleep? Y N
13. Do you suffer from bronchitis / tonsillitis / infection of the lungs? Y N / don't know
14. Do you have phlegm coming up from the lungs? Y N
15. Do you have any additional information that has not been mentioned in regards to your illness? Y N if yes please specify: