Patient Name: _____ DOB:_____

Acute Concern Questionnaire

Description of the problem

_____

_____

_____

_____

_____

How long ago did the problem start?

_____

Medications being taken:

_____

Drug Allergies:

_____

Has the patient had any of the following symptoms? (Circle all that apply)

Fever	*Diarrhea*	*Vomiting*	*Rash*
Cough	*Runny Nose*	*Pink Eye*	*Headache*
Lack or normal urine output		*Respiratory Distress*	
Stomach Pain	*Nausea*	*Itching*	*Sore throat*
Wheezing	*Constipation*		

(For office use only)

Weight_____kg Temp_____C Room#_____

Height_____cm BP_____/_____ Pulse_____