Patient Name: _____ Date: _____

Please check any symptoms you are currently experiencing:

- ☐ Fatigue
- ☐ Fever
- ☐ Double Vision
- ☐ Ear Discharge
- ☐ Eye Pain
- ☐ Ear Pain
- ☐ Eye Watering
- ☐ Facial Pain
- ☐ Facial Pressure
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Loss of Smell
- ☐ Nasal Congestion
- ☐ Nosebleed
- ☐ Ringing in Ears
- ☐ Sinus Pain
- ☐ Sinus Pressure
- ☐ Sleep Apnea (stop breathing when sleeping)
- ☐ Sneezing
- ☐ Snoring
- ☐ Sore Throat
- ☐ Swelling around the Eye
- ☐ Vertigo/Dizziness
- ☐ Visual Changes
- ☐ Runny Nose
- ☐ Difficulty Swallowing
- ☐ Neck Pain
- ☐ Neck Swelling
- ☐ Chronic Cough
- ☐ Hemoptysis (coughing up blood)
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Palpitation
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Heartburn
- ☐ Reflux
- ☐ Regurgitation
- ☐ Swelling of Extremities
- ☐ Dizziness
- ☐ Numbness
- ☐ Trouble Sleeping
- ☐ Bleeding Problems

☐ Other: _____

Pharmacy Name: _____

Pharmacy Address: _____