Sinus/Cold symptoms

1. Which of the following have you been experiencing?
    a. Congested nose
    b. Pain around the nose and face
    c. Headache
    d. Ear pain
    e. Neck pain
    f. Throat pain
    g. Cough
    h. None of the above

2. Have you had any of the following?
    a. Difficulty swallowing
    b. Difficulty breathing
    c. Difficulty seeing, or seeing blurry or double
    e. None of the above

3. Please enter a few details about your swallowing, breathing, or visual problems.

4. How long have you been having these symptoms?
    a. Just today
    b. For a few days
    c. For a week
    d. For one to four weeks
    e. For more than a month

5. Do you have fever?
    a. Yes, I have a low fever (lower than 101 degrees)
    b. Yes, I have high fever (101 degrees or higher)
    c. No, I do not have fever
    d. I don't know

6. How long have you been having fever?
    a. Just today
    b. For a few days
    c. For a week
    d. For one to four weeks
    e. For more than a month

7. Do you smoke?
    a. Yes
    b. Sometimes
    c. No

11. Did you used to smoke?
    a. I smoked regularly
    b. I smoked in the past, but not regularly
    c. I never smoked

8. Do you have any chronic illnesses, such as diabetes, heart disease, or lung disease, or any illness that weaken your body's ability to fight infection?
    a. Yes
    b. No
    c. I am not sure

17. Please enter the details of your other illness.

18. When you blow your nose, what color is the mucus?
    a. Mostly clear
    b. Mostly thin and yellow or green
    c. Mostly thick and yellow or green
    d. Mostly red or brown

9. Have you experienced similar problems in the past?
    a. Yes
    b. No

10. What treatments have worked in the past? What has not worked?

11. Is this illness similar to previous illnesses you have had? How is it the same? How is it different?

12. Have you recently been hospitalized?
    a. Yes
    b. No

13. Please enter a few details about when and why you were hospitalized?

14. What medications are you currently using for these symptoms?
    a. Decongestants
    b. Pain medicine
    c. Nose spray
    d. Antibiotics
    e. Nothing

15. Please enter the names of any medications you are taking, or any other treatments you are trying

16. Anything else to add?

End

Are you pregnant?
    a. I am pregnant.**
    b. I am confident that I am not pregnant.
    c, I think I might be pregnant.**

No
Yes
No
Yes
Yes
No
No
Yes
Yes
Yes
No
Yes