

**RUNNY NOSE / CONGESTION / UPPER RESPIRATORY INFECTION**  
(Example - seasonal / Allergic Rhinitis/Common Cold)

**Subjective Data:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Onset: \_\_\_\_\_  New Onset  Chronic  Recurrence

**History:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Sinus infection	<input type="checkbox"/> Upper respiratory infection
<input type="checkbox"/> Smoke	<input type="checkbox"/> Packs per day: _____	Number of years smoking: _____

**Associated Symptoms:**

<input type="checkbox"/> Nasal itching	<input type="checkbox"/> Stuffy nose	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Headache	<input type="checkbox"/> Non-productive cough
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Red eyes	<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Clear nasal discharge
<input type="checkbox"/> COPD	<input type="checkbox"/> Past Positive PPD	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Fever
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Hoarseness			
<input type="checkbox"/> Productive cough Describe: _____				
<input type="checkbox"/> Known allergen exposure Describe: _____				
<input type="checkbox"/> Pain elicited with pressure on forehead/cheek <input type="checkbox"/> Yes <input type="checkbox"/> No				

**Objective Data:** (clinically indicated VS)

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ Wt. \_\_\_\_\_

<b>Throat:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Red / inflamed	<input type="checkbox"/> White / patchy	<input type="checkbox"/> Pustules	<input type="checkbox"/> Clear drainage
<b>Nasal Mucosa:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Red / inflamed	<input type="checkbox"/> Swollen	<input type="checkbox"/> Tonsils	<input type="checkbox"/> Yellow/green drainage
<b>Lungs (right):</b>	<input type="checkbox"/> Clear	<input type="checkbox"/> Crackles	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Diminished
<b>Lungs (left):</b>	<input type="checkbox"/> Clear	<input type="checkbox"/> Crackles	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Rhonchi	<input type="checkbox"/> Diminished
<b>Neck Glands:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Swollen	<input type="checkbox"/> Tender to palpitation		
<b>Ears:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Red	<input type="checkbox"/> Drainage Describe: _____		
<b>Appearance:</b>	<input type="checkbox"/> No distress	<input type="checkbox"/> Mild distress	<input type="checkbox"/> Moderate distress	<input type="checkbox"/> Severe distress	

**NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:**

- |  |  |
|--|--|
| <input type="checkbox"/> Fever greater than 101 degree F or other signs of infection   | <input type="checkbox"/> Swollen, red, white patchy throat |
| <input type="checkbox"/> Symptoms of TB: night sweats, weight loss, productive cough, fever  | <input type="checkbox"/> Marked lymphadenopathy present    |
| <input type="checkbox"/> Offender returns with complications   | <input type="checkbox"/> There is history of severe COPD   |
| <input type="checkbox"/> There are symptoms or concerns of secondary bacterial infection: green or yellow purulent sputum or drainage from nose, ear pain, dyspnea |  |

**Refer to Medical Provider If:**

- |  |  |
|--|--|
| <input type="checkbox"/> Severe exacerbation       | <input type="checkbox"/> Yellow/green/blood tinged sputum/nasal drainage |
| <input type="checkbox"/> Purulent drainage         | <input type="checkbox"/> Severe pain over eyes/cheeks                    |
| <input type="checkbox"/> Unresponsive to treatment | <input type="checkbox"/> Cough lasting more than 2 weeks                 |

**Medical Provider/RN Notified: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Orders Received for Treatment:**  Yes  No

**Assessment:**

- Alterations in comfort and respiratory function related to  seasonal allergy  mild upper respiratory **congestion**

**Plan:**

**Nursing Intervention Routine: Do not use antihistamines with HTN and /or COPD**

- Encourage increase fluid intake
- Salt water gargles for throat discomfort
- Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4days **OR**
- Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days
- Chlorpheniramine (CTM) 4 mg p.o. three times daily for 8 days
- Guaifensin cough syrup 2 TEAspoon three times a day for 4 days – issue one bottle **OR**
- Guaifensin 200 mg 2 tablets three times a day for 4 days

**Progress Note:** \_\_\_\_\_

**Offender Education:**

- Instructed to increase fluids, medication use, avoid smoking, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

**LPN Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**RN/Provider Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Offender Name  
(Last, First)

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