

eWellness Questionnaire

Helping you one question at a time!

COLD OR FLU

Name: First Name	MI	Last Name	Date of Birth:
			Patient Code:

Please do not select anything if the answer is no or negative.
Select Rarely 'R' if this is an uncommon event or symptom.
Select Frequent 'F' if this is a common event or symptom.
Select Always 'A' if this is a persistent event or symptom. Also select 'A' for Yes

At first glance there may seem to be a lot of questions. But each of these questions were selected because of their direct or indirect relation to the symptoms mentioned.

Section 1

1. R F A Consume breads / pastas / starches 2. R F A Cough / spit clear sputum / phlegm

Section 2

3. R F A Drink coffee / soda / ice tea 8. R F A Consume refined carbs
4. R F A Smoke or use tobacco 9. R F A Consume wheat or gluten
5. R F A Consume sweets 10. R F A Consume artificial flavorings
6. R F A Drink cow's milk 11. R F A Family or financial stressors
7. R F A Consume white sugar

Section 3

12. R F A Vertigo / dizziness 17. R F A Itchy eyes
13. R F A Light headedness 18. R F A Puffy eyes
14. R F A Double vision or blurred vision 19. R F A Ear infections
15. R F A Dry or red eyes 20. R F A Tooth cavities
16. R F A Watery eyes 21. R F A Runny nose / sneezing

Section 4

22. R F A History of COPD / lung disease 26. R F A Wheezing with breathing
23. R F A History of chronic bronchitis 27. R F A Asthma
24. R F A Difficulty breathing deeply 28. R F A Shortness of breath
25. R F A Acute or chronic coughing 29. R F A Pain when taking a breath

Section 5

30. R F A Difficulty going to sleeping 33. R F A Cough / spit green-yellowish sputum / phlegm
31. R F A Difficulty staying asleep 34. R F A Fatigued or tired
32. R F A Too much stress / tension 35. R F A Thyroid medication

Section 6

36. R F A Hot flashes / sweats 37. R F A Sexually transmitted diseases

Section 7

38. R F A Chest pain / angina / tightness

Section 8

39. R F A Poor circulation in your hands

Section 9

40. R F A Headaches or migraines 42. R F A Back pain or neck pain
41. R F A Stiffness or muscle spasms 43. R F A Joint pain

Section 10

44. R F A Brain fog - lack of concentration

Section 11

45. R F A Anxiety / anxiousness

Name: First Name MI Last Name Date of Birth:

Patient Code:

Please do not select anything if the answer is no or negative.
Select Rarely 'R' if this is an uncommon event or symptom.
Select Frequent 'F' if this is a common event or symptom.
Select Always 'A' if this is a persistent event or symptom. Also
select 'A' for Yes

At first glance there may seem to be a lot of questions. But
each of these questions were selected because of their direct
or indirect relation to the symptoms mentioned.

Section 12

46. R F A Allergies

Section 13

47. R F A Sick more often

48. R F A Swollen glands

49. R F A Recently taken antibiotics

50. R F A Fever blisters or cold sores

51. R F A Warts

52. R F A Sore Throat