PATIENT NAME:_____

DATE OF BIRTH:_____

PHONE NUMBER: _____

INSURANCE NAME OR SELF PAY: _____

PRIMARY CARE PROVIDER: _____

PHARMACY: _____

TODAYS DATE:_____

REASON FOR TODAY'S VISIT:

_____

REVIEW OF SYSTEMS: (CURRENT SYMPTOMS)

Constitutional
- Fever
- Fatigue
- Chills
- Weakness

Respiratory
- Cough
- Sputum
- Wheezing
- Shortness of Breath

Eyes
- Vision Loss/Changes
- Pain
- Redness
- Discharge

ENT (Ears, Nose, Throat)
- Pain
- Ringing in Ears
- Hearing Loss
- Sore Throat
- Voice Hoarseness
- Post nasal drip
- Congestion
- Sinus Pressure

Cardiovascular
- Chest Pain
- Palpitations
- Shortness of breath with activity
- High Blood Pressure
- Swelling

Gastrointestinal:
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in Appetite
- Heartburn

Urinary
- Urgency
- Frequency
- Pain or Burning
- Blood in urine
- Incontinence

Musculoskeletal
- Muscle or joint pain
- Stiffness
- Back Pain
- Swelling
- Redness of joints

Skin:
- Rashes
- Lumps
- Itching
- Color Changes
- Dryness

Neurology
- Dizziness
- Headache
- Fainting
- Numbness
- Tingling
- Weakness

Psychiatric
- Nervousness
- Stress
- Depression
- Memory Loss
- Behavior Changes

PAST/CURRENT MEDICAL HISTORY:

Allergies (Medications/Food):

_____

_____

Medical History:

_____

_____

Surgical History:

_____

_____

Do you smoke or drink? (Social, Occasional, Former)

_____

Date of Last Menstrual Cycle: _____

Pregnant/Weeks: _____

Parents Health History:

Mother: _____

Father: _____

Daily Prescription Medications

Medication Name	Dosage

For Office Use

Weight: _____ Blood Pressure: _____ Pulse:_____ Temp:_____

Height: _____ Respiration Rate: _____ O2 Sat:_____

Test Ordered: INFLUENZA STREP COVID-19 ORAL COVID-19 NASAL COVID SOFIA MONO