	To Be Completed By Staff	
RT PCR Done ?	Yes No	Traveler? Yes No
Rapid Antibody IgM		
Rapid Antigen		

HEALTH HISTORY QUESTIONNAIRE & CONSENT TO TREATMENT

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Last Name:	First Name:	DOB: / /
SEX: M F	Email:	Phone:
Address:	Uninsured- Driver/ State ID/ SS # :	

Mark all symptoms you are having today:
None Sore Throat Cough Fever Chills Body Aches Shortness of Breath Nausea Vomiting
Diarrhea Loss of Smell Loss of Taste Other

Have you been exposed to anyone with COVID19? YES NO	Are you pregnant? (female only) YES NO Wks__________
Have you been previously tested positive for COVID19? YES NO	If yes, write date of your positive test: / /

Recent Travel Hx Country: City/ State:

Travel Dates:

Past Medical Hx: Diabetes Cancer Asthma COPD Other:
Current Medications:
Medication Allergies: NO YES Name of Medication: Type of Reaction
Smoking Hx: No Yes Cig Cigar Pipe Chew How Many: How Long:

By signing this form, I understand the following:
The laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practioners who may be in other areas, including out of state.

Signature of patient or responsible person/ party:	Date: / /
Print name of patient or responsible person/ party	Relationship:

THIS FORM MUST BE ENTIRELY COMPLETED BEFORE TESTING