

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

Daily Prescription Medications

Medication Name	Dosage

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: _____

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

