URGENT CARE By URGENT SPECIALISTS

COVID-19 Test MEDICAL HISTORY FORM

Name: _____ DOB: _____ Date: _____

Testing Facility	Urgent Specialists LLC – STL	Patient ID: (Chart #)	
Sex: M F	Ethnicity:	Zip Code:	

Reason for Testing (Required Field) You May Check More Than One.

	Close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 diagnosis in the past 14 days
	Travel, **date, AND Location:**
	Symptomatic of Disease
	Pre-Op Testing AND Surgery Center:

You Currently Experiencing Any Symptoms: (May Choose More Than One) ☐ **Yes** ☐ **No**

	Critically ill		Dyspnea/Trouble Breathing
	Not critically ill		Fatigue
	Acute Respiratory Distress Syndrome (ARDS)		Fever (greater than 100.4 F/38.0 C)
	Ageusia/Loss of Taste		Headache
	Anosmia/Loss of Smell		Malaise
	Arthralgia/Joint Pain		Myalgia/Muscle Pain
	Chills/Rigors		Pneumonia
	Conjunctivitis		Pneumonitis
	Cough		Rhinorrhea
	Diarrhea		Sore Throat

	Symptoms Onset Date:		**Suspected Infection Date:**

	PRIOR TESTING AND VACCINE INFORMATION	**Date(s):**
	Prior COVID Testing	
	COVID First Vaccine	
	COVID Second Vaccine	

Allergies to Medications:

Current Medications:

Significant Medical Hx: HTN, DM, CAD, COPD, Asthma, Lung Ca, Autoimmune Disease, RA

Surgical Hx: S/p Organ Transplant, Splenectomy

Smoking Hx:

Alcohol Use:

Drug Use:

Signed: _____ **Date:** _____

FOR INTERNAL USE ONLY:

SPECIMEN:

- ☐ ANTIGEN TEST (POC)
- ☐ PCR MicrogenDx **SALIVA**
- ☐ PCR MicrogenDx **NASAL**
- ☐ Blood Draw / Antibody
- ☐ COMBO – COVID /FLU A & B

RESULTS:

POSITIVE	NEGATIVE
O **Antigen**	O **Antigen**
O **Influenza A**	O **Influenza A**
O **Influenza B**	O **Influenza B**
O **Antibody IGM/IGG**	O **Antibody IGM/IGG**