PHS
Pediatrics & Vaccine Clinic

Name: _____ DOB: _____ AGE: _____

Address: _____ WEIGHT: _____

_____ HEIGHT: _____

Phone number : _____

Chief complaint/HPI : Coronavirus screening

Are you worried about COVID-19?	yes	no
Are you experiencing a fever or feel feverish?	yes	no
Are you having shakes/chills?	yes	no
Are you experiencing a cough?	yes	no
Are you experiencing shortness of breath?	yes	no
Are you having chest pressure/pain?	yes	no
Are you experiencing sore muscles?	yes	no
Are you experiencing loss of smell/taste?	yes	no
Are you experiencing headaches?	yes	no
Are you having a sore throat?	yes	no
Are you experiencing diarrhea?	yes	no
Are you experiencing nausea/vomiting?	yes	no
Do you have diabetes?	yes	no
Do you have high blood pressure?	yes	no
Do you have any heart/vascular disease?	yes	no
Do you have any respiratory disease?	yes	no
Do you have a low immune system?	yes	no
If female, are you pregnant?	yes	no

In the past 14 days, have you had contact with anyone suspected or known to have coronavirus, COVID-19?

yes no

Are you a healthcare worker who has been within 6 feet of a patient suspected of COVID-19 infection or have an occupation where you are in close contact with large numbers of people each day?

yes no

Do you live with, or frequently interact with people who are older than 60 years of age or who have chronic medical conditions (including cancer, heart disease, COPD, asthma, or immune disorders)?

yes no

I consent for the COVID-19 evaluation and testing. I authorize the release of medical information that is necessary for my further treatment. I authorize the release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered directly to PHS-Preventive Health solutions or any of its affiliates.

YES NO