Urgent Care Symptom Report

Patient Name:_____

Date of Birth:_____

What symptoms are bothering you most today?_____

What date did your symptoms start?_____

With this illness, have you had any of the the following symptoms? Please circle yes or no for each:

Yes No Fever
Yes No Chills
Yes No Sweats
Yes No Fatigue
Yes No Trouble sleeping
Yes No Confusion
Yes No Dizziness
Yes No Nasal congestion
Yes No Nasal drainage
Yes No Nausea
Yes No Vomiting
Yes No Diarrhea
Yes No Painful or swollen lymph nodes
Yes No Eye redness (Right or Left?)
Yes No Eye drainage/discharge/crusting (Right or Left?)
Yes No Eye itching (Right or Left?)
Yes No Loss of appetite
Yes No Change in taste or smell
Yes No Chest pain
Yes No Headache
Yes No Sore throat
Yes No Cough
Yes No Wheezing
Yes No Shortness of breath
Yes No Body aches
Yes No Rash
Yes No Sneezing
Yes No Post nasal drip
Yes No Ear pain (Right or Left?)
Yes No Eye pain (Right or Left?)

In the two weeks leading up to your symptoms starting, did you have any travel? Yes No

If yes, when and where?_____

In the two weeks leading up to your symptoms starting, did you have any known close contact exposures of COVID19? Yes No If yes, who and when?_____

Are you fully vaccinated for COVID19? Yes No

Have you had a lab confirmed case of COVID19 in the last 6 months? Yes No

Are you interested in COVID testing today? Yes No

Phone number to reach you in your car:_____

What type and color of vehicle are you in?_____