XPRESS URGENT CARE
WALK IN CLINIC

COVID History form

A. **My Information:**

1 Name: Last: _____ First: _____ Middle: _____

2. Date of Birth: _____/_____/_____

3. Gender: ☐ Male ☐ Female

B. **Current Symptoms**:

1. I CURRENTLY have fever/chills ☐ Yes ☐ No
2. I CURRENTLY have shortness of breath ☐ Yes ☐ No (IF YES PLEASE CALL 911 OR GO TO ER)
3. I CURRENTLY have cough ☐ Yes ☐ No
4. I CURRENTLY have chest pain ☐ Yes ☐ No (IF YES PLEASE CALL 911 or GO TO ER)
5. I have new onset loss of taste or smell ☐ Yes ☐ No
6. I have body aches ☐ Yes ☐ No
7. I have nasal congestion, sore throat, runny nose ☐ Yes ☐ No
8. Other current symptoms : _____

C. **My Active Medical Conditions:**

1. Asthma/COPD ☐ Yes ☐ No
2. Diabetes ☐ Yes ☐ No
3. Cancer ☐ Yes ☐ No
4. Autoimmune disease ☐ Yes ☐ No
5. Heart Disease ☐ Yes ☐ No
6. Other Chronic Medical Conditions: _____

C. Medications I take daily:

☐ I am currently not on any medications

☐ My list of medications are : _____ _____ _____

_____ _____ _____

G. Allergies

☐ I have no known medication allergies

☐ I am allergic to _____ _____ _____

C. My Social History:

1. I smoke cigarettes	☐ Yes	☐ No
2. I smoke marijuana	☐ Yes	☐ No
3. I use illicit Drugs (cocaine, heroine, meth, ect)	☐ Yes	☐ No
4. I vape	☐ Yes	☐ No

By placing my signature below, I hereby certify that the information I provided above is true and correct.

Print Name: _____

Signature:_____ Date: _____/_____/_____

Name of school:_____