Primary Medical Care Visit Update Form

Name: ____ **Date**: __________________

(Last) (First) (Middle)

Date of Birth ____/_______/_____ Phone ___________________ Email __________________________

Reasons for Visit: ☐Cough ☐Sinus ☐Fever ☐Pain ☐Other:____

How long have you had this condition: _________ Days _________ Months __________ Years?

Allergies: ___________________________________ Do you Smoke? ☐ Yes ☐ No

Have you recently fallen: Y N

Review of Symptoms: Are you experiencing or have experienced any of the following within the last seven days?

1.) Constitutional: ☐ No Symptoms ☐ fever ☐ fatigue

2.) Skin: ☐ No Symptoms ☐ hives ☐ rash ☐ warts

3.) Ear,Nose & Throat: ☐ No Symptoms ☐ ear ache ☐ sinus pressure ☐ nose discharge ☐ sore throat

3.) Eyes & Head: ☐ No Symptoms ☐ headaches ☐ double vision ☐dizziness

4.) Respiratory: ☐ No Symptoms ☐ shortness of breath ☐ cough ☐ wheezing ☐ chest pain with breathing

5.) Recent Travel: ☐ No ☐ yes-please specify: ________________________________

6.) Contact with confirmed Covid-19 cases: ☐ No ☐ yes-please specify: ________________

Please send a picture of your completed forms to **pmcpcmh@gmail.com**.