

Primary Medical Care Visit Update Form

Name _____ Date: _____, 2020
(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.