COVID QUESTIONS
International Travel Clinic
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Today's Date: _____

Patient Name: _____ _____
Last **First**

Date of Birth: _____/_____/_____
Month/Day/Year

Telephones: Home:_____ **Cell:** _____

Address: _____**Zip:** _____

Email: _____

List any chronic medical problems or current symptoms you have:
_____
_____

List any allergies you have:
_____
_____

List any medications you take:
_____
_____

Have you had COVID infection? **Yes** _____ **No** _____
Have you had exposure to person with COVID? **Yes** _____ **No** _____
Recent history of fever or congestion: **Yes** _____ **No** _____

Are vaccines up to date: Yes_____ **No**_____ **Unsure**_____
Date of last menstrual period (if applicable):_____

Please list the specific questions you have:
_____
_____

Current Weight: _____

Patient Signature: _____ **Date:** _____