Point of Care Testing for COVID19

Patient Intake and Assessment Form

Middletown Family Pharmacy

877 Main St Belford NJ 732-471-9100

Revised 11/2020

Patient Name: _____ Gender: _____ Birthday: _____
FIRST MI LAST

Patient Address: _____City/State/Zip: _____
NUMBER ROAD

Patient Phone Number: (____) _____-_____ Weight: _____

Credit Card Number: _____ Exp Date: __/_____ CVV: ____

E-Mail Address:_____

Primary Care Physician: _____ Address: _____
FIRST LAST STREET NAME

Medication Allergies:_____

Current Medications:_____

Past Medical History:_____

Current Situation – When did your symptoms start? _____

Which of these do you currently have?

Fever:	Y / N If yes, what temperature? _____		
Cough:	Y / N	Vomiting:	Y / N
Diarrhea:	Y / N	Shortness of Breath:	Y / N
Chills:	Y / N	Sore Throat:	Y / N
Muscle Pain:	Y / N	New Loss of Taste or Smell:	Y / N

Have you taken any medications for these symptoms? Y / N

If yes, what and when? _____

Do you have any of the following medical conditions?

__Asthma or Chronic Lung Disease __Diabetes

__Serious heart condition, such as congestive heart failure __ Pregnancy

__Diseases or conditions that make it harder to cough __Extreme obesity

__Kidney Failure or end stage renal disease __Cirrhosis

__Conditions that result in a weakened immune system including cancer treatment

Have you been prioritized by your local health department for testing? Y / N

Are you a health care worker, first responder, or law enforcement officer? Y / N

Do you live or work in a treatment facility, group home, or other group setting? Y / N

Are you a caregiver for an elderly person or someone with a weakened immune system? Y / N