Living Medical Arts PLLC.

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Client History Form – COVID-19 Symptoms

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Client Information **Today's Date:**

NAME: LAST	FIRST	MI	Date of Birth Age	**M / F**
Street Address		City	State	Zip Code
Phone Numbers Home:	Cell:		Work:	
Email Address:				
Referred By:	How did you hear about us?			
Main Reason for Visit 1.			Duration	
2.			Duration	
Please circle any current symptoms or exposures: fatigue shortness of breath diarrhea				
loss of sense of smell GI upset cough Other: **Known exposure to COVID 19- please elaborate:**				
Primary Care Physician: Address:			Date of Last Physical Exam: Telephone:	
Practitioner (if not PCP):			Address: Telephone:	

Past Medical History	
Any predisposing conditions for Covid 19 exacerbations? https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fneed-extra-precautions%2Fgroups-at-higher-risk.html **Hypertension, Obesity (BMI of >30), Over 65 years old, Diabetes, Cardiovascular and Vascular Disease, Cancer, Immune suppression, Chronic Kidney Disease, COPD, Sickle Cell Disease**	
Reason/Diagnosis	Year

Current Medication			
Medication Name	Dose & Frequency	Approx. Start Date	Reason for Use

Supplements & Over-the-Counter Medications			
Supplement/Medication	Dose & Frequency	Approx. Start Date	Reason for Use

Allergies □ *NO KNOWN ALLERGIES*	
Do you have any allergies to any of the following:	If yes, please list the allergen(s) and the reaction(s) experienced:
Chemicals	
Drugs (over-the-counter or prescription)	
Herbs	
Inhalants	
Other	
Perfumes	
Pets	

Screening		
Basic Tests	**Last date done**	**Results (+ or -) and state findings**
Blood work, incl. cholesterol		
Cardiac test (EKG, echo, stress, etc.)		

Colonoscopy		
Dermatologist		
Mammogram (women)		
MRI		
Ophthalmologist		
PAP Smear (women)		
Physical		
Prostate Exam, PSA (men)		
Thyroid		
Ultra Sound/CT Scans		
Other:		

Medical & Family History- *Please select which applies to you or your family below*

	Self	Family		Self	Family		Self	Family
Alcohol Abuse			Gallbladder disease/stone			Migraines or Headaches		
Allergies			Glaucoma			Mumps		
Anemia			Gout			Obesity/Overweight		
Arthritis			Heart Attack/ Angina			Osteopenia/Osteoporosis		
Asthma/COPD			Heart Failure (CHF)			Other Psychiatric Illness		
Cancer: (type)			Heart Valve Disorder			Palpitations		
Chicken Pox			High Blood Pressure			Polio		
Cholesterol			High Blood Sugar			Pulmonary HTN		
Colitis			HIV			Rheumatic Fever		
Constipation			Hyperthyroidism			Seizures		
Dementia			Hypothyroidism			Shortness of Breath		
Depression/ Anxiety			Insomnia			Sleep Apnea		
Diabetes Mellitus			Irregular Heart beat			Strep/Tonsillitis		
Dizziness			Kidney Disease/ stones			Stroke		
Diarrhea			Liver Disease			Thyroid Disorder		
Drug Abuse			Loss of Concentration			Tuberculosis		
Ear Infections			Loss of Consciousness			Ulcers		
Eating Disorder			Measles			Other		
Eczema/Skin Issues			Memory Loss					

Personal & Social History	**Y**	**N**		**Y**	**N**
Do you work with the public? Do you wear a mask?			Are you socially distancing? Have you already tested positive for COVID19?		

I have answered the above to the best of my abilities.

Client or Guardian Signature _____ **Date** _____