

CRFHT COVID ASSESSMENT MEDICAL HISTORY FORM

If requested by the nurse during your triage call, please fill out this Medical History Form and bring it with you to your appointment.

You are being seen by the Clarence-Rockland Family Health Team's Febrile and Respiratory Illness clinic. You will be assessed only for your current illness, and testing such as a nasopharyngeal swab may be offered. You may be prescribed medication and given advice relating to your current illness, but no medication refills outside of this will be renewed or prescribed. Follow-up should be done by your regular provider.

Demographic inform	nation				
First Name		Last Name			
Date of Birth (d/m/y)		Family physician			
Do you have any of	the following?				
Lung Disease (asthma, COPD, other)				□ Yes	□ No
Heart Disease				□ Yes	□No
Hypertension				□ Yes	□ No
Immune Disorder - Specify:				□ Yes	□ No
Kidney Disease				□ Yes	□ No
Diabetes				□ Yes	□No
Cancer – Specify:				□ Yes	□ No
Are you pregnant? **If yes, what is the first day of your last menstrual period?				□ Yes	□No
Other serious diagnosed medical problems – Specify:				□ Yes	□No
Any surgeries? Specify:				□ Yes	□ No
Do you have any allergies to medication? Specify:				□ Yes	□ No
Are you taking any r you might be taking		st all prescribed medica	ations a	and suppl	ements
Name of medication	Dose	Frequency	Reas	Reason for medication	