PREMIER MEDICINE
Medical Center

"WE ARE HERE FOR YOU"

www.PremierMedicine.com

Name: **Patient #**

DOB: **Date:**

Vitals:

Temp. **F°** **Pulse** **O2Sat**

Have you experienced any of the following symptoms?	YES	NO
• Fever of 100.4 degrees or greater or chills	○	◉
• Cough	◉	○
• Shortness of breath or difficulty breathing	○	○
• Headache	○	○
• Sore Throat	○	○
• Are you vaccinated for COVID-19?	○	○

Have you been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19? ○ ○

Do you want to be seen by one of our Providers by Tele-Medicine video call? ○ ○