



**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**

**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?**