PARADIGM
FAMILY HEALTH

Date: ____________________
Physician: ____________________

Testing Visit Form

First Name:	Last Name:	Address Line 1:
City:	State:	Address Line 2 (Apt, St, etc.):
Zip Code:	DOB:	Gender/Sex:
Phone Number:	Email:	Race:
Occupation:	Employer:	Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Reason for Visit:	Recent Known Exposure? ☐ Yes ☐ No	Date Symptom Onset:
Recent Travel:	How Exposed:	

HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means. The information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

☐ Cell Phone:
- ☐ Ok to leave message with detailed message
- ☐ Leave name and doctor with call back number only
- ☐ Ok to text message with detailed message

I consent and authorize the release of medical information, including diagnosis, treatment and results to the following:

☐ My employer: ____

☐ Other: ____

Patient Signature   Date

Please indicate if you have had any of the following symptoms: ☐ None

☐ Fever (Max Temp: _______) ☐ Chills ☐ Night Sweats ☐ Fatigue ☐ Dizziness ☐ Headache ☐ Dry Cough ☐ Productive Cough
☐ Runny Nose ☐ Congestion ☐ Sneezing ☐ Body Aches ☐ Loss of Smell ☐ Sore Throat ☐ Loss of Taste ☐ Ear Pain
☐ Loss of Hearing ☐ Numbness ☐ Vision Disturbances ☐ Sensitivity to Light ☐ Itchy Eyes ☐ Red Eyes ☐ Shortness of Breath
☐ Chest Pain ☐ Palpitations ☐ Excessive Sweating Abdominal Pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation
☐ Other: ____

Please indicate if you have any of the following medical conditions:

☐ Seasonal Allergies ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Heart Disease ☐ Kidney Disease ☐ Liver Disease
☐ Cancer ☐ HIV/AIDS ☐ Anemia ☐ Emphysema/COPD ☐ Asthma ☐ Other:________________________________

Hospitalized recently? If so, what dates and which hospital? ________________________________

Any known allergies to medications?________________________________

Any medications on a daily basis including birth control?________________________________

Any tobacco use? If so, how often and how much per day?________________________________

Recent testing and results?________________________________

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FOR OFFICE USE ONLY

Test Type: _PCR_ Result: _Positive/Negative_ Initial: ____________ Date of Result: ______________________