

The Doctors' Office Urgent Care
556 PASSAIC AVENUE
WEST CALDWELL NJ 07006
973-808-2273

DATE: _____

Full Name _____ Date Of Birth _____

Cell Phone Number _____

Have you been tested for Covid-19 in the past? Yes _____ No _____

Negative or positive at that time? NEGATIVE _____ POSITIVE _____

Are you currently symptomatic? Yes _____ No _____

If yes, please list symptoms and duration below.

Do you have any allergies to medications? Yes _____ No _____

If yes, please list allergies below.

Do you take any medication? Yes _____ No _____

If yes, please list medications below.

Do you have any past medical history? Yes _____ No _____

If yes, please list history below.

Do you have any surgical history? Yes _____ No _____

If yes, please list below.

Do you smoke? Yes _____ No _____

Do you drink alcohol? Yes _____ No _____

For office use only:

TEMP: _____

HEART RATE: _____

O2: _____