Blue Med Consultants
COVID-19 Testing Intake Form

Full Name _____

Date of birth _____

Address _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Email _____

Do you have any of the following symptoms?

- ☐ Fever greater than 100.4
- ☐ Cough
- ☐ Shortness of breath/difficulty breathing
- ☐ Runny nose
- ☐ Sore throat
- ☐ Body aches/chills
- ☐ Loss of taste or smell
- ☐ Headaches
- ☐ Cramping
- ☐ Nausea, diarrhea
- ☐ Other: _____

Have you been in contact with anyone with COVID-19 symptoms or confirmed positive?

Have you recently traveled to an area that is experience a surge in COVID-19 cases?