COVID-19 Pre Triage Questionnaire

Name:_____ Date:_____

DOB: _____

Allergies:

_____

Medication currently taking/frequency/MG:

_____

_____

Diagnosis:
(For each RX)
_____

_____

_____

Any surgeries?

_____

_____

Height:_____ Weight:_____

**First Day of Last Menstrual Cycle:* _____ **Pregnant:_____Y_____N_____*

**If applicable*