GALAXY HEALTH

YOUR COVID 19 SOLUTION

Call 915-302-9095 text 915-206-5635

www.galaxyhealthus.com www.intellimedicine.org

HEALTH HISTORY QUESTIONAIRE

Name____

Date of Birth_________________Date of visit________________

Employer____

Employer address (work site)_____________________________

First visit?______Second visit?_______Third visit?__________

Recent exposure to one who tested positive to Covid 19?____

Days of symptoms_______Fever?_______How high?________

Cough?___________shortness of breath?________

Muscle aches?_______nasal symptoms?_______nausea?____

Abdominal pain?____change in taste?______change in sense of smell?________recent travel to Mexico?________________

Recent travel to New York, Louisiana, Detroit?______________

Have you had an antibody test done by anyone in the past?_______when and what lab?___________Have you had a pcr (nasal, sputum, pharyngeal swab) COVID test?________

When and with what lab?________________________________

Allergies to medications: list all____

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Medications that you take: list all including the dose____

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List medical problems that you have____

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Please upload a copy of your immunization history and send via the secure email. What is the name and address of your pharmacy?_______________________________________