PORTLAND URGENT CARE

DATE _____

_____ X _____

NAME Signature

DOB

YES ☐ NO ☐ *In the past 90 days, have you been diagnosed with COVID-19?*
If yes, date:

YES ☐ NO ☐ *Did you have close contact with anyone with acute respiratory Illness or confirmed COVID-19 Infection in the last week?* *If yes, date:*

YES ☐ NO ☐ *Did you travel outside of Country in the past 14 days?* *If yes, date:*

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In the last 14 days, have you had any of the following symptoms?	Current	Past	NONE
1. Chills	☐	☐	☐
2. Fever	☐	☐	☐
3. Cough	☐	☐	☐
4. Nausea	☐	☐	☐
5. Vomiting	☐	☐	☐
6. Headaches	☐	☐	☐
7. Shortness of breath	☐	☐	☐
8. Difficulty breathing	☐	☐	☐
9. Sore throat/Difficulty swallowing	☐	☐	☐
10. Pink eye (conjunctivitis)	☐	☐	☐
11. Diarrhea/Abdominal pain	☐	☐	☐
12. Decrease or loss of sense of taste or smell	☐	☐	☐
13. Unexplained fatigue/malaise/muscle aches (myalgias)	☐	☐	☐
14. Runny nose/nasal congestion without other known cause	☐	☐	☐

PUC Employees ONLY

Test Performed by: _____ Temperature: _____
Please Print

Method:

Rapid Antigen	Rapid Antigen	Rapid Molecular	RT-PCR
Quidel Sophia-2	BD Veritor	Abbott	Accula