Magnificat Family Medicine, LLC
Casey L. Delcoco, M.D.
8240 Naab Rd. Suite 416
Indianapolis, IN 46260
Office 317.306.5588
Fax 317.550.1544
www.magnificatfamilymedicine.com

URGENT COVID Questionnaire

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Current Height:** _____

Email address: _____ **Current Weight:** _____

Phone Number: _____

Address: _____

_____

_____

PLEASE INCLUDE a PICTURE or SCAN of your ID & INSURANCE CARD WITH THIS FORM.

Insurance Information:

Name of Insurance: _____
Gaurantor (policy holder): _____
Member ID: _____
Group #: _____
Billing & Claims Address: _____
_____
_____
EDI #: _____

In order to provide complete and accurate care, please complete the following questions and return to: frontdesk@magnificatfamilymedicine.com AS SOON AS POSSIBLE. Your plan, history and medication review, and any prescriptions CANNOT be executed until complete and accurate!

1. Have you previously had COVID-19? Yes No Date: _____

2. List ALL ***medications* - *supplements* - *vitamins*** in detail including dosages, what date started for each:

Medication/Supplement & Dosage:	Date:

Medication/Supplement & Dosage:	Date:

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3. Please list any ALLERGIES to medications/foods/etc.:

Allergy Causing Agent:	Type of Reaction (i.e. rash, nausea, etc.):

--New patients: all sections must be completed before scheduling--

****Current patients ONLY may skip to page 6****

4. Please provide your PAST MEDICAL HISTORY; check ALL that apply - use 'other' for those not listed:

____ Allergies
____ Anemia
____ Angina (chest pain)
____ Anxiety
____ Arthritis
____ Asthma
____ Atrial fibrillation
____ BPH (enlarged prostate)
____ Blood clots
____ Cancer, type_____
____ CVA (stroke)
____ COPD (emphysema)
____ CAD (hear disease)
____ Crohn's disease
____ Depression
____ Diabetes
____ Gallbladder disease
____ GERD (reflux)
____ Hepatitis C
____ High cholesterol
____ High blood pressure
____ Irritable bowel disease
____ Liver disease
____ Migraine headaches
____ MI (heart attack)
____ Osteoarthritis
____ Osteoporosis
____ Peptic ulcer disease
____ Renal disease (kidneys)
____ Seizure disorder
____ Thyroid disease

Other_____ _____

5. Please provide your PAST OPERATIONS:

Type of Operation	When it happened
_____	_____
_____	_____
_____	_____
_____	_____

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6. FEMALES ONLY (OB & GYN History):

Are you having periods? Yes No

If "no", are you: Menopausal

Hysterectomy

Other (Please Specify):_____

_____

How many pregnancies have you had? _____

Number of living children: _____

7. Please provide your relevant SOCIAL HISTORY:

Do you Smoke? Yes No Former

Type of tobacco: _____
Packs per day: _____
Years smoked: _____
Years quit: _____

Do you drink Alcohol? Yes No Former

Type of alcohol: _____
Frequency and Amount: _____
When was your last drink? _____

Do you use illegal drugs? Yes No Former

Type of drug: _____
Frequency and Amount:_____

8. Does anyone in your FAMILY have the following? (check ALL that apply - use 'other' for those not listed)

____ Breast Cancer
____ Colon Cancer
____ Diabetes
____ Heart Issues
(heart attacks, heart failure, etc.)

____ Mood disorders
(anxiety, depression, bipolar, etc.)
____ Skin Cancer
____ Strokes

____ autoimmune disease
(lupus, rheumatoid arthritis, etc.)
Other:_____
_____
_____

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9. AUTHORIZATION to communicate MEDICAL INFORMATION:

I authorize that Magnificat Family Medicine, LLC, may communicate with me regarding appointments and scheduling, lab results, as well as but not limited to, brief treatment and follow-up instructions, and which may be communicated by the following : (please select each box for acceptable method)

Home answering machine/voicemail	Cell phone voicemail
Work voicemail	Secure email
Secure text message	Other _____

I authorize Magnificat Family Medicine, LLC to communicate with the follow listed persons regarding my medical information: (Please include authorized person's name)

1. _____
2. _____
3. _____

I authorize the release of my medical records to consulting specialists or facilities for the continuation of care as deemed necessary by my physician.

I affirm that ALL information provided above are true, accurate, and complete. I give express consent for communication preferences, authorized persons, and release of medical records for continuation of care as enumerated above in number 9. I have had (or will have) access to information regarding benefit, risk, health plan, and have had (or will have) the opportunity to ask my specific questions of Magnificat Family Medicine and its medical staff regarding preventive care and early treatment of COVID-19. Health care plans, medical treatments and/or interventions are a personal choice made in consultation with medical providers; as such, I understand the benefits, risks, plan, and prevention and treatment in the COVID-19 protocol. Magnificat Family Medicine, LLC will not be held responsible for inaccurate or incomplete information or failure to follow or comply with COVID-19 protocols outlined in my plan.

_____***Name*** _____***Date***

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt and/or access to Magnificat Family Medicine, LLC's, *Notice of Privacy Practices*, containing description and disclosures of treatment of my health information (found here: http://magnificatfamilymedicine.com/images/pdfs/NoticeOfPrivacyPractices.pdf). I understand that Magnificat Family Medicine, LLC may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy by submitting a request in writing to the office or by going online to www.magnificatfamilymedicine.com.

Printed Patient Name _____

Patient Signature _____

Date Signed _____

Date of Birth _____

If completed by Patient's Authorized Person (parent/guardian), please print name and sign below.

Printed Authorized Person's Name _____

Signature of Authorized Person _____

Relationship to patient _____

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Please indicate your preferred pharmacy:

Pharmacy Name: _____
Address: _____
_____
_____
Phone Number: _____

As part of the COVID Prevention and/or COVID Ready Early Treatment Plan, your provider may prescribe medicine not covered by insurance or not available at many pharmacies. We work with local pharmacies to ensure medications are available and cost effective. The compounding pharmacy for ivermectin ($0.35/mg) and hydroxychloroquine ($40 for 10 day supply):

Dr. Aziz Compounding Pharmacy
7320 E 82nd Street
Indianapolis, IN 46256
317.842.5771
www.drazizrx.com

(Dr. Aziz will submit to insurance, however, it may not be covered.)

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URGENT COVID Questionnaire: Your Symptoms

1. When did you first start having symptoms? Date: _____
2. When did you have a positive test? Date: _____
3. **Check the box** for any/all your symptoms below:

	PAST	PRESENT
a. Fever, if so, how high has your temperature been?	☐	☐
i. Highest temperature: _____		
b. Chills	☐	☐
c. Muscle or body aches	☐	☐
d. Fatigue	☐	☐
e. Sore throat	☐	☐
f. Headaches	☐	☐
g. Sinus/nasal congestion or runny nose	☐	☐
h. Cough – productive (circle one)?	☐	☐
➔ If cough still present, what color phlegm/sputum_____		
i. Shortness of breath or difficulty breathing	☐	☐
j. Wheezing	☐	☐
k. Nausea/vomiting	☐	☐
l. Diarrhea	☐	☐
m. New loss of taste or smell	☐	☐

4. Are you checking oxygen levels with oximeter? YES NO

➔ If not, buy one ASAP and start checking. If YES, list the range of your oxygen levels, if it dropped, when it dropped, etc.

➔ _____

6. Have you previously had COVID-19? ☐ Yes ☐ No Date: _____
7. Have you received any COVID-19 vaccinations? ☐ Yes ☐ No Date(s): _____

➔If so, which ones? _____

8. Other concerns:

_____

_____