



Garrison Family Medical Group
Nurturing mind, body and spirit

**Welcome to Garrison Family Medical Group, Inc
Antelope Valley Urgent Care**

Patient Name: _____ Date: _____

Please read this and respond:

1. Reason for your visit today _____
2. Do you have any of these symptoms? (Circle)

| | | | |
|-------------------------|-------------------|-------------------------------|------------------------|
| Fever or chills | Cough/dry cough | Shortness of breath | Fatigue |
| Diarrhea | Muscle/body aches | Headache | Loss of taste or smell |
| Abdominal pain | Sore throat | Congestion or runny nose | Nausea or vomiting |
| Tiredness | Aches and pains | Conjunctivitis | Rash |
| Difficulty breathing | Fatigue | Discoloration of fingers/toes | Chest pain |
| Loss of speech/movement | | | |

3. Have you or anyone in your household been tested for **COVID-19** in the past month?

YES OR NO

4. Have you or anyone in your household had **COVID-19?** YES / NO
5. Have you had 1 or more doses of the **COVID-19 VACCINE?** YES / NO

If YES, when 1: _____ 2: _____

6. I do **NOT** have any of those symptoms.

PATIENT SIGNATURE

DATE