

Name: _____

Date: _____

Medical history

Pre-existing conditions:

Covid-19 vaccinations:

Covid-19 infections:

Post-Covid since when:

Examinations already completed:

Treatments already tried:

Additional information:

Symptoms

1)

2)

3)

4)

5)

6)

7)

8)

Current diagnoses

1)

2)

3)

4)

5)

6)

7)

8)

Abnormal laboratory results & tests

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•	•

Additional information:

My questions

- 1)

- 2)

- 3)

- 4)

- 5)

- 6)

- 7)