



PRE-VISIT CHECK IN FORM

AIMA of Nashua, PLLC is committed to your health and safety. State of NH and federal public health officials recommend reducing physical contact, limiting discussion during treatment, and decreasing overall time in the office in order to mitigate risk of COVID-19 and other transmissible diseases. Thank you for doing your part in protecting yourself, your community, and your health care providers by submitting this form to us in advance of your appointment. Please submit it well in advance so we will have time to review it before you are seen. You may return it via secure patient portal or call us at 603-718-8328. Voicemail is available 24 hours/day and 7 days/week. *This form must be submitted before each visit in order for you to be seen. Please complete it well in advance, and no later than 24 hours, before your appointment.*

What would you like your provider to address during your visit? *Please be specific and provide details:* _____

Have you had any other symptoms, concerns, or conditions experienced in the last week? If yes, please describe severity, frequency, when it started, and all other details: _____

Have you had any recent life changes or events that may be affecting your health? If yes, please describe: _____

Have you had any new diagnoses, testing, or blood work since your last visit? If yes, please describe: _____

Please list any **new** vitamins, supplements, topical preparations, or prescriptions since your last visit: _____

Please list any **new** sensitivity or allergy to foods, environment, or drugs since your last visit: _____

Do you need refills on previously prescribed medicinals from this office? If yes, please list: _____

Do you answer “yes” to any of the questions below? If yes, please provide details: _____

- Within the past 21 days have you been in any area with a congregation of people including, but not limited to: stores, markets, meetings, conferences, trade shows, classes, organized events, or concerts?
- Within the last 24 hours have you had a fever of 100°F (38°C) or above?
- Within the past 21 days, do you or have you had symptoms including but not limited to: sore throat, new loss of taste or smell, cough, runny nose, sneezing, fever or feeling feverish, chills, shaking with chills, shortness of breath, difficulty breathing, headache, new body aches or muscle pain, skin changes or rash, nausea, gastrointestinal upset, abdominal pain, vomiting, diarrhea, stroke, blood clot, delirium or confusion?
- Within the past 21 days have you been exposed to any person (including children) with suspected or confirmed COVID-19? (Healthcare workers caring for COVID-19 patients while wearing appropriate PPE should answer no to this question).
- Within the past 21 days, have you traveled: a) internationally, b) by cruise ship, c) domestically (within the USA) outside of NH, VT, or ME on public transportation (bus, train, airplane, etc.), or d) to or from any area within or outside of the USA that is currently experiencing COVID-19 outbreak?
- Have you been in close contact with any person (including children) who has, within the last 21 days, traveled: a) internationally, b) by cruise ship, c) domestically (within the USA) outside of NH, VT, or ME on public transportation (bus, train, airplane, etc.), or d) to or from any area within or outside of the USA that is currently experiencing COVID-19 outbreak?

PRINT NAME OF PATIENT: _____

RELATIONSHIP TO PATIENT (self, guardian, etc.): _____

PRINT NAME OF GUARDIAN (if applicable): _____

DATE TODAY: _____

DAY, DATE, AND TIME OF YOUR APPOINTMENT: _____

SIGNATURE: _____