



ตอบคำถามเท่าที่ตอบได้นะคะ

PATIENT ASSESMENT / TESTING

Date Patient Called for appt: _____ Appt Date: _____ Time: _____ By: _____
 Temperature: _____ Height: _____ Weight: _____
 Test results: [] POSITIVE [] NEGATIVE
 Pt request results letter: [] YES [] NO Date mailed: _____

ข้อมูลส่วนตัวบุคคล

PATIENT QUESTIONNAIRE FOR COVID-19

**ชื่อย่อ

Initials

First Name _____ Last Name _____
 Address: _____ ZIP: _____
 Phone: _____ Email: _____
 DOB: _____ Age: _____ SS#: _____ Sex: M F
 Health Care Plan _____ Phone#: _____
 Primary Care Physician: _____ Phone#: _____

* Are you filling this form out because you are concerned that you have been exposed to or have contracted the COVID-19 virus? [] YES [] NO
 Explain: _____

* Are you experiencing any of the following symptoms?
 [] Fever or chill (ไข้สูงเกิน 100 F) [] Coughing (ไอ) [] Nasal Congestion or discharge (คัดจมูก) [] Body aches (ปวดเมื่อยตัว)
 [] Difficulty breathing or shortness of breath (หายใจลำบากหรือหายใจตื้น) [] Nause/vomiting (คลื่นไส้ / อาเจียน) [] Headache (ปวดหัว) [] Muscle pains (เจ็บหน้าอก)
 [] Chest pain (เจ็บหน้าอก)

* Do you have any of the following pre-existing medical problems?
 [] Diabetes, type 1 or 2 (เบาหวานประเภท 1 หรือ 2) [] High Blood Pressure (ความดันโลหิตสูง) [] High Cholesterol (คอเลสเตอรอลสูง)
 [] Cardiovascular Disease (Heart Attach/Stents/Heart Failure) (โรคหัวใจและหลอดเลือด (หัวใจวาย/ใส่ตลวด/หัวใจล้มเหลว))
 [] Lung Disease like COPD, Asthma or Emphysema (โรคปอด เช่น COPD หอบหืด โรคที่เกี่ยวข้องกับปอด)
 [] Autoimmune Disease like Lupus or Rheumatoid Arthritis (โรคภูมิแพ้ตัวเอง เช่น โรคลูปัส หรือ ไขข้ออักเสบ)
 [] Medications that affect the immune system (ยาที่มีผลต่อระบบภูมิคุ้มกัน) [] I have none of these (ไม่มีโรคใด ๆ ข้างต้น)

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**ช่วง 14 วันก่อนตรวจได้ เดินทางไปที่ไหนที่มีการระบาด COVID-19 หรือไม่

*** Have you traveled during the last 14 days from anywhere there is community transmission of COVID-19?**

IYES JNO

**คุณมีความใกล้ชิด ชิดกับผู้ป่วยหรือผู้ติดเชื้อ COVID-19 หรือไม่

*** Where have you travel during the last 14 days, where you may have been exposed to COVID-19?**

**คุณได้สัมผัสโดยตรงกับผู้ป่วยที่เข้ารับการรักษาในโรงพยาบาลแล้ว ว่าเป็นผู้ติดเชื้อ COVID-19 หรือไม่

*** Have you had direct exposure to a COVID-19 patient?**

- Live with a known COVID-19 patient Cared for a known COVID-19 patient
- Been in the same room as a known COVID-19 patient
- Been around someone exposed to a COVID-19 patient

**ชื่อย่อ

Initials

*** Have you had any other exposures or interactions with anyone who has a laboratory confirmed case of COVID-19?**

Walking by someone briefly in the same room or indoor confined space don't know

History & Physical Examination

Addressograph

Physical Exam (Complete each item. Explain abnormal.)

Height: _____ Weight: _____ (kg) Vitals: BP: _____ P: _____ R: _____ T: _____

PHYSICAL EXAMINATIONS		Normal (check)	Abnormal (comment)	N.A.
EENT	Pupils equal & reactive; tympanic membrane clear & intact; throat clear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	Regular rate, rhythm; no murmurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen/Groin	Soft; no masses; no tenderness No hernias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CNS	Cranio, sensory, & motor systems intact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic/G.U.	Pelvis without masses or pain to palpation; External genitalia normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	Healthy, no excoriations, weeping, infection, lesions	<input type="checkbox"/>	D	<input type="checkbox"/>
Breasts	No dominant masses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal	No palpable masses; Prostate normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL:	No gross structural abnormalities			
IMPRESSIONS				
1) _____		3) _____		
2) _____		4) _____		
PLAN: _____				

Physician Signature completing H & P _____

Date _____

Elite Care Medical Group
13794 Beach blvd. Ste. B
Westminster, CA. 92683
Office (714) 379-3088
Website: elitecaremg.com

NO: _____

COVID Antibody Results

Patient Name: _____ Birthday: _____ Test Date: _____

Thank you for coming to test today. Thank you for your patience as we work diligently to provide you the best, most efficient care. Please see your results from your recent IgG/IgM antibody testing.

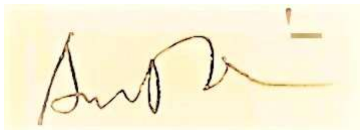
__ **IgM**- This immunoglobulin or "antibody" is indicative of a recent infection with COVID. If you have IgM, you have come in contact with COVID and your body is making antibodies to fight it off. Because this test is so new, we are recommending that anyone that has a positive IgM POC test, also get the full nasal swab to confirm. In the meantime, please isolate yourself at home, wear a mask if you must go out {I.e. doctor appointments). Please consult your physician.

__ **IgG**- This marker, in the absence of IgM, indicates that you DID contract COVID at some point, and your body fought it off. You now have antibodies for this disease. The chances of you . contracting COVID are probably very close to 0%.

__ **IgM AND IgG**- You likely have come in contact with the COVID within the past 1-2 weeks. Your body has antibodies. Your risk of contracting COVID again is nearly 0%. Please consult your physician.

__ **NO IgG nor IgM**- You DO NOT have COVID at this time (likely with 90% certainty). Nor has your body developed antibodies against COVID. You are still at normal risk to contract COVID.

Next steps: Just because you have a negative test, it does not mean that you do not have some other disease nor does it indicate that you 100% cannot get infected in the future. We still recommend consulting with your physician and obeying orders such as "social distancing" and -"frequent handwashing". This situation is very fluid, so please stay informed and responsible.



Anthony H. Dinh, M.D. D.O.