ACUTE GROUP A STREPTOCOCCAL PHARYNGITIS INFECTION

PATIENT INFORMATION *(Please print clearly)*

Last Name:	**First Name:**	**D.O.B.:**	**Age:**	**Gender:**	**Height:**	**Weight:**
Home Address:			Contact Phone:			
City:			State:		Zip:	
Primary Care Physician:			Physician Phone:			
Physician Address:			Physician Fax #:			
Please state any past medical history and chronic conditions:						
Current medications:						
Allergies (please state reaction that occurs when exposed to the allergen):						

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Are you currently experiencing any of the following symptoms: fever, headache, sore throat, pain while swallowing, lymph node tenderness or swelling, inflammation of tonsils/throat?	☐	☐	☐
Have you had Streptococcal Pharyngitis infection confirmed by a Rapid Antigen Detection Test (RADT) test?	☐	☐	☐
For women: Are you currently pregnant or breastfeeding?	☐	☐	☐
Do you have history of kidney dysfunction?	☐	☐	☐
Do you currently have a condition such as cancer, leukemia, or HIV/AIDS that weakens your immune system?	☐	☐	☐
Are you currently taking cortisone, prednisone, other steroids, anticancer drugs or had any radiation treatment?	☐	☐	☐
Are you currently experiencing any of the following symptoms: runny nose, oral ulcers, cough, hoarseness?	☐	☐	☐
Have you been treated with antibiotics for sore throat or upper respiratory tract infection in the past 30 days?	☐	☐	☐
Do you have a history of rheumatic fever, rheumatic heart disease, scarlet fever, or Group A Streptococcal Pharyngitis-induced glomerulonephritis?	☐	☐	☐
Are you currently experiencing any of the following symptoms: Altered mental status, low blood pressure, increased heart rate, increased breathing rate, fever?	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per day?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐