Board Certified
Family Medicine
in Kailua

STUART LERNER, MD

TOTAL BODY MEDICINE

Traditional and Holistic Medicine

Ph: 808-954-4463
Learn more at
www.dr-lerner.com

---

1. Have YOU OR a household family member or a coworker tested positive for COVID 19? Yes No

2. Have you had in the last 7 days any symptoms of: (Circle all that apply) * If none circle no
   Fever Chills Headache Body aches Fatigue Cough Short of breath
   Change in sense of taste or smell ? Yes No

3. Have you had any direct exposure to a Covid positive person in the last week? Yes No
4. If you think you were exposed to COVID : were you without a mask ? N/A Yes No
   were you indoors at the time? Yes No
5. Are you an essential or health care worker with any contact with COVID patients? Yes No
6. Have you been at a public or work gathering or live in a multiple family household with close contacts with NO masks? Yes No

7. Do you have any exposure to a high risk group: frail /elderly over sixty-five, anyone with asthma emphysema cancer diabetes or chemotherapy? Yes No

8. Have you had any recent travel outside the state? Yes No

9. Do you have: Diabetes hypertension cancer asthma obesity heart disease other? Yes No

---

Name_____ M F Temp_____ Pulse _____Pulse Ox____% RR_____

Address_____State HI_____ Zip Code_____

phone_____ email_____.com_____Date of Birth:____/____/____

Primary medical insurance _____Subscriber number _____
Secondary medical insurance_____Subscriber number_____
Hawaii License or ID number_____ Soc Sec #_____

Initial all

_____ By signing this form I agree and consent to allow Stuart Lerner, MD or his appointees to:
_____ --Assess, test and treat me and allow for follow up by telehealth as needed
_____ --Bill my medical insurance and collect payment directly from my insurance(s)
_____ --Allow billing service, the lab, or third parties, access to my personal health information above to process claims arising from medical services
_____ --I further agree to be fully responsible and pay any amounts due for any physician or staff services or lab fees not covered or paid by insurance.

Signature:_____ **Date: Aug 30, 2020** Test ordered-Covid 19 PCR Nasoph

If you do not have ID, we can not test you.