Acute Group A Streptococcal Pharyngitis Patient Form

PATIENT INFORMATION

Name		Date of Birth	Age
Address		Phone	Email
City	State	Zip	County
Primary Care Provider			
Medication Allergies			
Current Medications (Rx, OTC, herbal, topical, pain or allergy, supplements, vitamins, etc.):			
Treatments tried for current condition (if none, indicate N/A):			

PATIENT ELIGIBILITY

☐Yes ☐No Are you 18 years of age or older?
☐Yes ☐No Are you pregnant or breastfeeding?
☐Yes ☐No Have you ever been diagnosed with a weakened immune system (e.g., cancer, HIV/AIDS, transplant, long-term steroids, etc.)? If yes, explain:
☐Yes ☐No Do you have a history of rheumatic fever, rheumatic heart disease, scarlet fever, or acute GAS pharyngitis induced glomerulonephritis?
☐Yes ☐No Do you have a history of allergic reactions to antibiotics, such as penicillin, amoxycillin, cephalexin, clarithromycin, or clindamycin?
☐Yes ☐No Do you have a pending test for your symptoms (COVID, strep, flu)?
☐Yes ☐No Have you had a tonsillectomy in the previous 30 days?
☐Yes ☐No Have you taken antibiotics in the last 30 days? If yes, why?
When did your symptoms start? ☐More than four days ago. ☐Fewer than four days ago
Do you have any of the following symptoms (check all that apply)? ☐Fever ☐Sore throat ☐ Pain swallowing ☐Swollen/tender cervical lymph nodes ☐Inflamed or swollen tonsils or uvula ☐Other:

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