



COVID-19 and Influenza (Flu) Medical History Form: Adults 65 Years and Older

Please complete this form with information about your COVID-19 and influenza (flu) medical history. This form is for your personal use. It will help you develop an action plan to prevent the flu and/or COVID-19 and prepare for unexpected illness. An action plan is a summary of steps you can take to protect yourself and your loved ones from the viruses that cause the flu and COVID-19.

First Name: _____ Last Name: _____ Date of Birth: _____

PREVENTION

Flu Vaccination

Date of last flu shot: _____

COVID-19 Vaccination

Date of last COVID-19 shot: _____

How many COVID-19 shots have you received? _____

SYMPTOMS

Flu and COVID-19 Symptoms

If you became ill with the flu and/or COVID-19, did you have any symptoms?

Yes No (asymptomatic)

Which of the following symptoms did you have?

- Cough
- Shortness of breath or difficulty breathing
- Fatigue (tiredness)
- Sore throat
- Runny or stuffy nose
- Muscle pain or body aches
- Headache
- Vomiting
- Diarrhea
- Change in or loss of taste or smell
- Other: _____

TESTING

Flu Testing History

Have you ever tested positive for the flu?

- Yes – Date last tested positive: _____
 No

COVID-19 Testing History

Have you ever tested positive for COVID-19?

- Yes – Date last tested positive: _____
 No

Did you test positive with a rapid at-home test?

- Yes No

Did you test positive with a PCR laboratory test?

- Yes No

Did you test positive with a rapid at-home test **and** a PCR laboratory test?

- Yes No

Flu and COVID-19 Testing History

Have you ever tested positive for the flu and COVID-19 at the same time?

- Yes – Date last tested positive: _____
 No

Did you test positive with an at-home test?

- Yes No

Did you test positive with a laboratory test at a medical facility?

- Yes No

TREATMENT

Flu Treatment

If you became ill with the flu, did you receive any treatment?

- Yes No

Which of the following antiviral medicines were you prescribed?

- Oseltamivir (available as a generic version or under the brand name Tamiflu)
- Zanamivir (brand name: Relenza)
- Peramivir (brand name: Rapivab)
- Baloxavir (brand name: Xofluza)

Date treatment started: _____

COVID-19 Treatment

If you became ill with COVID-19, did you receive any treatment?

- Yes No

Which of the following COVID-19 treatments did you receive?

Antiviral treatment

- Nirmatrelvir/ritonavir (brand name: Paxlovid)
- Remdesivir (brand name: Veklury)
- Molnupiravir (brand name: Lagevrio)

Monoclonal antibody

- Bebtelovimab

Date treatment started: _____

Did you receive treatment at a Test to Treat location?

- Yes No

COMPLICATIONS

Flu Complications

If you became ill with the flu, did you have serious complications?

- Yes No

Which of the following complications did you have?

- Pneumonia
- Inflammation of the heart (myocarditis), brain (encephalitis), or muscle tissue (myositis, rhabdomyolysis)
- Multi-organ failure (for example, respiratory and kidney failure)
- Other: _____

Were you hospitalized for these complications?

- Yes No

Date of hospitalization: _____

COVID-19 Complications

If you became ill with COVID-19, did you have serious complications?

- Yes No

Which of the following complications did you have?

- Pneumonia
- Inflammation of the heart (myocarditis), brain (encephalitis), or muscle tissue (myositis, rhabdomyolysis)
- Multi-organ failure (for example, respiratory and kidney failure)
- Long COVID-19 complications (for example, headache or brain fog)
- Other: _____

Were you hospitalized for these complications?

- Yes No

Date of hospitalization: _____

When to Contact Your Doctor

Contact your family doctor if you have any signs or symptoms of the flu or COVID-19. Explain your condition and follow your doctor’s advice for testing and treatment.

If you don’t have a family doctor, now is a great time to establish care with one. They can help you with all your health needs, including prevention and treatment of illnesses like the flu and COVID-19.