Covid-19 Questionnaire

Patient Disclosure

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current diseases or medical conditions), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

In the past two weeks, have you had any of the following symptoms:

Temperature of 100.4 or above	YES	NO	Loss or reduction in your sense of taste or smell	YES	NO
Shortness of breath	YES	NO	Muscle or body aches	YES	NO
Trouble breathing	YES	NO	Headaches	YES	NO
Dry cough	YES	NO	Nausea	YES	NO
Runny nose	YES	NO	Vomiting	YES	NO
Congestion	YES	NO	Diarrhea	YES	NO
Sore throat	YES	NO			

Have you been in contact with someone who has texted positive for Covid-19 in the past 2 weeks?	YES	NO
Have you tested positive for the COVID-19?	YES	NO
Have you been tested for COVID-19 and are awaiting results?	YES	NO
Have you traveled outside the United States by air or cruise ship in the past 14 days?	YES	NO
Have you traveled within the United States by air or train within the past 14 days?	YES	NO

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any condition in my health history which may result in a compromised immune system. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Printed Name_____

Signature_____ Date_____