COVID-19 QUESTIONAIRE & PATIENT DISCLOSURES

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 disease or medical condition), 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 with us.

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.

Do you have cold or flu-like symptoms such as a fever, cough, runny nose, or sore throat?

☐ Yes ☐ No

Have you experienced shortness of breath or had trouble breathing?

☐ Yes ☐ No

Do you have muscle pain?

☐ Yes ☐ No

Have you recently lost or had a reduction in your sense of smell or taste?

☐ Yes ☐ No

Have you had gastrointestinal symptoms like nausea, diarrhea, or abdominal pain?

☐ Yes ☐ No

Have you tested positive for COVID-19?

☐ Yes ☐ No

Have you been in contact with someone who is sick in the last 14 days?

☐ Yes ☐ No

Have you traveled to a COVID-19 dense area or taken a plane, bus, ship, or train in the last 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 conditions 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.

Full Name	Signature	Date	Temperature
	Signature	Date	Temperature
	Signature	Date	Temperature
	Signature	Date	Temperature
	Signature	Date	Temperature