

## COVID-19 QUESTIONNAIRE & 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.

Have you been vaccinated against COVID-19?

Yes     No    If yes, vaccine name: \_\_\_\_\_ 1<sup>st</sup> Vaccine Date: \_\_\_\_\_  
2<sup>nd</sup> Vaccine Date: \_\_\_\_\_ Last Vaccine Date: \_\_\_\_\_

Have you tested positive for COVID-19?

Yes     No    If yes, when did you test positive? \_\_\_\_\_

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 or body aches?

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 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    If yes, where did you go? \_\_\_\_\_

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

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Signature                                      Date                                      Temperature

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