COVID-19 PANDEMIC PATIENT DISCLOSURES

_____ _____

Patient's Name Date of Birth

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19, also known as "Coronavirus," pandemic.

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 such disclosures may impact treatment decisions.

People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. It is important that you disclose 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-Office Screening	
	Yes	**No**
Have you or anyone in your household been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you or any one in your household tested positive for COVID-19?	☐	☐
Have you or any one in your household been tested for COVID-19 and are awaiting results?	☐	☐
Outside church or school have you been in a crowd of 10 people or more in the past 14 days?	☐	☐
Have you taken any fever-reducing medications or symptom altering medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other), or aspirin, DayQuil or other cough and cold medicne in the last 14 days and, if yes, for what reason? _____	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a cough?	☐	☐
Do you have a runny nose?	☐	☐
Do you have sore throat?	☐	☐
Do you have muscle pain?	☐	☐
Have you experienced chills or repeated shaking with chills?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐	☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐	☐

****Turn page to sign →**

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I fully understand and acknowledge the above information, risks and cautions and have disclosed to my provider any other conditions in my health history. By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature (optional) Date

Patient Temperature:_____ PO2:

Guest Temperature:_____ PO2:

Asked to go home: ☐ Yes, time:_____ am pm ☐ No

Revised May 15, 2020