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.

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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Pre-Appointment** | |  | **In-Office** | |
| **Yes** | **No** | **Yes** | **No** |
| Have you been in contact with someone who has tested positive for COVID-19? | ☐ | ☐ | ☐ | ☐ |
| Have you been tested for COVID-19? | ☐ | ☐ | ☐ | ☐ |
| Have you traveled outside the United States or to high-risk areas in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Have you felt like you have had a fever or above normal temperature in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Have you taken any fever-reducing medications, including: ibuprofen (Advil, Motrin or other), acetaminophen (Tylenol or other), naproxen (Aleve or other) or aspirin in the last 14 days and, if yes, for what reason? | ☐ | ☐ | ☐ | ☐ |
| Have you experienced shortness of breath, or had trouble breathing? | ☐ | ☐ | ☐ | ☐ |
| Do you have, or have you had a cough in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Have you recently lost or had a reduction in your sense of smell or taste? | ☐ | ☐ | ☐ | ☐ |
| Do you have, or have you had a sore throat in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Have you experienced chills or repeated shaking with chills in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Do you have new onset generalized muscle pain in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Do you have, or have you had any other flu-like symptoms, such as gastrointestinal upset, headache, fatigue, or diarrhea in the past 14 days? | ☐ | ☐ | ☐ | ☐ |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | ☐ | ☐ | ☐ | ☐ |

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

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Patient or Legal Representative Signature Date

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Print Patient or Legal Representative Name