COVID PATIENT INTAKE

Patient Name:____________________ Date:__________

Due to the highly contagious nature of Coronavirus COVID-19, we require that you answer the following questions to ensure the health and safety of our patients and community.

1. Do you currently have a fever, or symptoms of upper respiratory infection such as cough, sore throat, or shortness of breath? ____ YES ____ NO

2. Within the last 14 days, have you traveled to restricted countries or locally affected areas (either domestically or internationally)? ____ YES ____ NO

3. Have you had contact with someone with known or suspected COVID-19? ____ YES ____ NO

4. Have you been vaccinated? ____ YES ____ NO

If yes, name of vaccine:_________________________

How many shots have you received at this time?_______

For Office Use: Temp_____________________________