Do not write, stamp, punch holes or affix a sticker in this area.

COVID-19 Assessment

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PATIENT'S FIRST NAME | MIDDLE INITIAL | PATIENT'S DATE OF BIRTH (Month / Day / Year)

Primary High Risk Condition (choose one):

- ◯ Chronic Lung Disease
- ◯ Diabetes
- ◯ Immunocompromised
- ◯ Heart Disease
- ◯ **None**

Primary Underlying Health Conditions (choose one):

- ◯ Asthma
- ◯ Cancer / Chemotherapy / Radiation
- ◯ Cerebral Palsy
- ◯ Chronic Bronchitis
- ◯ Chronic Hepatitis
- ◯ COPD
- ◯ Cirrhosis of Liver
- ◯ Congestive Heart Failure
- ◯ Diabetes
- ◯ Diabetic Limb Amputation
- ◯ Dialysis
- ◯ Emphysema
- ◯ Epilepsy (Seizure Disorder)
- ◯ Heart Disease
- ◯ HIV or AIDS
- ◯ Hypertension
- ◯ Immunosuppressant Medications
- ◯ Kidney Disease
- ◯ Muscular Dystrophy
- ◯ Obesity (BMI >40)
- ◯ Oral Steroids
- ◯ Other Immunocompromised Condition
- ◯ Other Liver Disease
- ◯ Other Lung Condition
- ◯ Other Neurological Condition
- ◯ Pregnancy
- ◯ Spinal Cord Injury
- ◯ Stroke / History of Stroke
- ◯ Transplant (Organ or Bone Marrow)
- ◯ **None**

List other conditions here:

_____

Smoking Status

- ◯ Non-Smoker
- ◯ Smoker

Smoking Method

- ◯ Cigar
- ◯ Cigarettes
- ◯ Vaping / eCigarettes

Have you been in contact with someone diagnosed with COVID-19?

- ◯ Yes ◯ No ◯ Unknown

Have you been in contact with someone with cold/flu symptoms?

- ◯ Yes ◯ No ◯ Unknown

Are you displaying any known symptoms of COVID-19?

- ◯ Yes ◯ No ◯ Unknown

For how long? Days: 1 2 3 4 5 6 7 / 8 9 10 11 12 13 14

Fever

- ◯ Yes ◯ No ◯ Unknown

Temp.: 97 98 99 100 101 102 103 104 105 (.0 .1 .2 .3 .4 .5 .6 .7 .8 .9)

	Yes	No	Unknown
Chills or Shaking with Chills	◯	◯	◯
Cough	◯	◯	◯
Headache / Severe Headache	◯	◯	◯
Loose Stools or Diarrhea	◯	◯	◯
Muscle Pain	◯	◯	◯

	Yes	No	Unknown
New Loss of Taste or Smell	◯	◯	◯
Shortness of Breath	◯	◯	◯
Sore Throat	◯	◯	◯
Vomiting	◯	◯	◯

Other Symptoms

_____