Covid-19 Medical Assessment Form

Name: ___________________________________

Date of Birth: _____________________________

Type of Procedure: ____________________________ Date of Procedure: ________________________

HISTORY

Have you or anyone in your household been diagnosed with Covid-19? ❐Yes ❐No

Have you or anyone in your household been within 15 feet of a person with a lab diagnosed case of Covid-19 for at least 5 minutes? ❐Yes ❐No

Have you or anyone in your household traveled outside of the country in the last 30 days? ❐Yes ❐No

Have you or anyone in your household traveled to any areas deemed to have a high concentration of confirmed Covid-19 cases in the last 30 days? ❐Yes ❐No

Have you or anyone in your household had exposure to any "Person(s) Under Investigation" (PUI) for Covid-19? ❐Yes ❐No

Have you or anyone in your household traveled to, reside and or work in local areas that have reported Covid-19 cases? ❐Yes ❐No

Review of Symptoms: *(please check all that apply in the past 14 days)* ❐ Fever / Fever like Symptoms

❐ Shortness of breath or severe wheezing ❐ Muscle Aches ❐ Headache ❐ Decrease in your ability to

Taste or Smell ❐ Fatigue or Loss of Energy ❐ Stomach Issues ❐ None of the Above

Patient Signature: ________________________ Print: ________________________ Date:_____________

PHYSICAL EXAMINATION *To be confirmed by provider on site. Check all that apply*

❐ Fever of 100.5 or higher ❐ Dry Cough ❐ Flu Like Symptoms
❐ Sore Throat ❐ Difficulty Breathing ❐ Headache

Additional Findings:
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Provider Signature: _______________________ Print: ________________________ Date:_____________