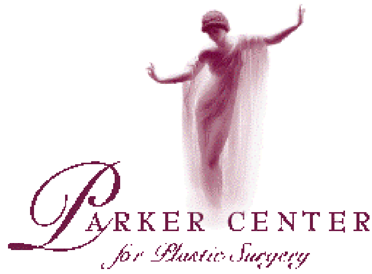

Wellness Form

Patient name: ____

Do you have a cough or shortness of breath? Yes No

OR at least two of the following (please indicate with a check mark next to it):

- o Current fever (>100.4'F) or fever within the last 24 hours
- o Chills
- o Repeated shaking with chills
- o Muscle pain
- o Headache
- o Sore throat
- o New loss of taste / smell

If you have any of the following, please indicate with a check mark next to it:

- o Rash
- o Diarrhea or vomiting
- o Any contagious condition (pink eye, strep, flu, etc.):

Have you traveled outside the country or recent domestic travel to an area with any outbreak of a known contagious condition and not completing the isolation and quarantine recommendations as set by the CDC?

Yes No

Have you had COVID-19 or come in contact with someone experiencing symptoms of COVID-19 in the last 7-14 days?

Yes No

In the last two weeks have you worked or volunteered in a hospital, emergency room, clinic, medical office, long-term care facility or nursing home, ambulance service, first responder services, or any health care setting or taken care of patients as student or part of their work?

Yes No If yes, please specify: ____

____

<u>If you have any of the following conditions, please indicate with a check mark next to it:</u>

o Chronic lung disease, moderate to severe asthma, or smoking

o Serious heart conditions

o Weakened immune system (cancer treatment, prolonged use of steroids, transplant or HIV/ AIDS)

o Severe obesity (Body Mass Index [BMI] greater than or equal to 40)

o Underlying conditions (diabetes, renal failure, or liver disease)

o Pregnancy

o None of the above

Patient Signature: ____ Date: _____________________________