COVID-19 Patient Disclosures

Given the current circumstances regarding COVID-19, it is important for us to know if you or anyone in your household has been exposed to COVID-19 or are currently experiencing any signs or symptoms assoiciated with the virus.

To allow us to ensure the safety of our office for both patients and staff, please answer the questionnaire below.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or difficulty breathing?	☐	☐
Do you have a dry cough?	☐	☐
Have you recently lost or had a reduced sense of taste or smell?	☐	☐
Have you or anyone in your household been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you or anyone in your household tested positive for COVID-19?	☐	☐
Have you or anyone in your household been tested for COVID-19 and are awaiting results?	☐	☐
Have you or anyone in your household traveled outside the United States in the past 14 days?	☐	☐
Have you or anyone in your household traveled outside of Texas in the past 14 days?	☐	☐
Have you been in close contact with anyone who recently travedled outside of Texas and was sick?	☐	☐
Do you have a compromised immune system (i.e. diabetes, COPD, cancer, other chronic medical conditions)?	☐	☐

A weak or compromised immune system can put you at a higher risk for contracting COVID-19.
I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system.

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

Patient Name: ______________________________ Date: _______________________

Signature: ____