COVID-19 PRE-TREATMENT QUESTIONS

Please complete and return this form before your treatment. Thank you.

Today's Date

Your Name	

Have you had COVID-19?	**YES/NO**
Do you currently have any symptoms of COVID-19?	**YES/NO**
Does anyone in your household have symptoms of COVID-19?	**YES/NO**
Have you been in close contact with anyone outside your household in the past 10 days who has COVID-19 or symptoms of COVID-19?	**YES/NO**
If you have had COVID-19 or the vaccination are you currently experiencing any side effects ?	**YES/NO**
Have you arrived in the UK from abroad in the past 14 days?	**YES/NO**

If answering yes to any of the above, please provide further details.

Signature.....