Urgent Care

MEDSTOP

Madonna Plaza

COVID-19 "RISK" ASSESSMENT FORM

NAME: _____ DOB: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING… YES OR NO

DIAGNOSTIC RISK:

HAVE YOU HAD CLOSE CONTACT, IN THE LAST TWO WEEKS, WITH A CONFIRMED CASE OF COVID-19? YES NO

HAVE YOU TRAVELLED, IN THE LAST TWO WEEKS, TO AN AREA WITH A LOT OF KNOWN COVID-19 INFECTIONS? YES NO

HAVE YOU HAD A FEVER RECENTLY ? YES NO

DO YOU HAVE A SIGNIFICANT COUGH? YES NO

HAVE YOU BEEN SHORT OF BREATH OR FATIGUED RECENTLY ? YES NO

PATIENT ASSOCIATED RISK:

DO YOU HAVE SIGNIFICANT HEART DISEASE? YES NO

DO YOU HAVE SIGNIFICANT LUNG DISEASE? YES NO

DO YOU HAVE DIABETES, TREATED WITH MEDICATION? YES NO

ARE YOU ON MEDICATIONS THAT SUPPRESS YOUR IMMUNE SYSTEM? YES NO

HAVE YOU BEEN TREATED FOR CANCER RECENTLY? YES NO

ARE YOU OR COULD YOU BE PREGNANT? YES NO

If it is determined that you need testing for COVID-19 and would like to receive a copy of your results, please sign and date below authorizing release of information to be sent to you via e-mail.

Signature: _____ Date: _____

Email address: _____