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
RECENTLY, HAVE YOU HAD A FEVER?	YES	NO
DO YOU HAVE A SIGNIFICANT COUGH?	YES	NO
RECENTLY, HAVE YOU BEEN SHORT OF BREATH OR FATIGUED?	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
RECENTLY, HAVE YOU BEEN TREATED FOR CANCER?	YES	NO
ARE YOU OR COULD YOU BE PREGNANT?	YES	NO

Signature: _____ Date: _____

Email address: _____