Communicable Disease Screening Form

If you have been exposed to a communicable disease, you may spread the disease to the practitioner, staff, or other patients/visitors in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission and ensure the safety of the practice and its visitors

Select whichever apply to you *

- [ ] I have not received any doses of any COVID-19 vaccinations.
- [ ] I have received my first dose of the Johnson & Johnson vaccine.
- [ ] I have received a booster dose of the Johnson & Johnson vaccine.
- [ ] I have received my first dose of the Moderna or Pfizer vaccine.
- [ ] I have received my second dose of the Moderna or Pfizer vaccine.
- [ ] I have received one or more booster doses of the Moderna or Pfizer vaccine.

Please write the date (can be approximate, e.g. November of 2021) of your last COVID-19 vaccine dose. If none, enter, "N/A" *

Have you been in contact with someone who has tested positive for COVID-19 or is suspected of having COVID-19 in the last 14 day…

- ( ) Yes ( ) No

Have you been tested for COVID-19 in the last 14 days? *

- ( ) No
- ( ) Yes, tested positive
- ( ) Yes, tested negative
- ( ) Yes, no results yet

Have you had close contact with someone who has tested positive for or has a suspected case of Monkeypox in the last 14 days? *

- ( ) Yes ( ) No

Have you been tested for Monkeypox in the last 14 days? *

- ( ) No.
- ( ) Yes, tested positive.
- ( ) Yes, tested negative.

Do you, others accompanying you today, or anyone you or they have been in contact with within the last 14 days have any of the following novel symptoms (not due to a pre-existing condition such as chronic fatigue syndrome or asthma)?

Fever (defined as above 100.4° F degrees)? *

- ( ) Yes ( ) No

Chills or repeated shaking with chills? *

- ( ) Yes ( ) No

Cough? *

Sore throat? *

Yes No

Yes No

New loss of taste or smell? *

Yes No

Shortness of breath or having trouble breathing? *

Yes No

Headache? *

Yes No

Body aches (e.g. muscle aches, backache)? *

Yes No

Nasal congestion? *

Yes No

Fatigue/malaise? *

Yes No

Swollen Lymph Nodes *

Yes No

Itchy or painful rash with pustules, blisters, or scabs? *

Yes No

Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? *

Yes No

If you selected YES to any of the questions above provide the approximate dates of the symptoms

Start Date

End Date

If you had a Monkeypox rash, have the lesions fully healed and the affected regions developed a new layer of skin?

Yes No

Agree & Acknowledge

- I understand that if I answer yes to any of these questions I may be asked to reschedule my appointment to a later date.
- I agree to notify the clinic if I become ill with COVID-19 symptoms or test positive for COVID-19 within 14 days of my appointment.
- I understand the clinic has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days of my appointment.
- By signing, I assert that the above are true and correct to the best of my knowledge.
- By signing, I agree to wear a well-fitted face mask over my nose and mouth for the duration of my appointment. Masks should always have multiple layers if made of fabric. Ideally, masks should include at least one layer of non-woven material (e.g. a surgical mask under a fitted cloth mask; a cloth mask with a non-woven filter; a KN95 or an N95 mask). Masks should not have vents. I understand that a staff person may ask me to wear a surgical mask provided on site, and I agree to do so if asked.

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Draw your signature

Type It Draw It Clear