BRUCE P. ROBINSON, MD
PATIENT COVID-19 QUESTIONNAIRE

Name:

Date:

1. **Have you had any COVID-19 symptoms in the past 14 days? (Respiratory illness, new shortness of breath or difficulty breathing, fever, chills. Muscle pain, new cough or runny nose, new sore throat, headaches or new loss of taste or smell, new vomiting or diarrhea)**

Circle one: Yes or No

2. Have you been in contact with anyone who has been ill or tested positive for COVID-19 in the past 14 days?

Circle one: Yes or No

3. Have you traveled outside of NY, NJ, or CT in the past 14 days? If yes, where have you traveled?

Circle one: Yes or No

4. Has anyone in your household traveled outside of NY, NJ, or CT in the past 14 days? If yes, where have you traveled?

Circle one: Yes or No

5. ONLY the patient will be allowed in the office, UNLESS they are a minor, in which case they may be accompanied by ONE parent.

Initial: _____

6. Patients and visitors will be required to wear a face mask/face covering at ALL times while in our building and office.

Initial: _____

Have you had a Covid Vaccine yet?

Moderna/Pfizer: Dose 1 ___ Date: _____
Dose 2 ___ Date: _____

Johnson & Johnson ___ Date: _____