DELAND
WELLNESS CENTER

Test Date:
Dates Revised:

COVID-19 PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: ☐ M ☐ F	**DOB:**
Height:	**Weight:**

Testing

IgM/IgG for COVID-19 for screening purpose.

- Please abide by CDC guidelines for COVID-19
- Contact your physician if you develop symptoms including shortness of breath, cough, chest pain, GI symptoms.

Your COVID testing for screening purpose:

IgG: Negative IgG: Positive so we recommend PCR testing
IgM: Negative IgM: Positive so we recommend PCR testing

Your results will be reported to the Health Department as required by law.

You MUST speak to your employer for your company policy. We recommend compliance with the current CDC recommendations and this can be found at: www.cdc.gov

Please contact your physician or hospital with any questions or if your symptoms worsen, please contact the ER, and let them know your COVID-19 results.

Provider Signature: _____

Patient Signature: _____

Deland Wellness Center is a privately owned facility. We are not affiliated with any other private/public entity, hospital or government entity.

COVID-19 PATIENT QUESTIONNAIRE

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK YES OR NO				
Are you a First Responder or Health Care Professional	☐	Yes	☐	No
Are you over the age of 65	☐	Yes	☐	No
Fatigue	☐	Yes	☐	No
Dry Cough	☐	Yes	☐	No
Shortness of Breath	☐	Yes	☐	No
Muscle Pain or Joint Pain	☐	Yes	☐	No
Sore Throat	☐	Yes	☐	No
Headache	☐	Yes	☐	No
Chills	☐	Yes	☐	No
Nausea or Vomiting	☐	Yes	☐	No
Nasal Congestion	☐	Yes	☐	No
Diarrhea	☐	Yes	☐	No
Recent loss of taste or smell	☐	Yes	☐	No
Have you been in contact with anyone who has been confirmed to be COVID-19 positive?	☐	Yes	☐	No