ALLERGY & ASTHMA CENTER
Adult & Pediatric Care

Allergy/Respiratory/Cutaneous Status

Patient Name:_____ DOB:_____ Date:_____

This questionnaire is designed to optimize safety precautions already in place for your evaluation. The Clinical staff will review your responses and notify your provider if they have any questions or concerns about whether you should receive your service(s) today. **If you are pregnant or have been diagnosed with a new medical condition, please notify the staff.** PLEASE CIRCLE **Yes** or **No and** the **SPECIFIC SYMPTOMS** you are experiencing or have experienced if applicable.

1. Have you or anyone with whom you live traveled in the last past two weeks? Yes/No
2. Have you had a fever, cold, sore throat, respiratory infection, body aches, chills or flu like symptoms in the last past 2 weeks? Yes/No
3. Have you had an increase in Asthma symptoms (chest tightness, increased cough, wheezing, or shortness of breath) in the past 1-2 weeks? Yes/No
4. Have you been diagnosed with Asthma? Yes/No
5. Have you had recent loss of taste or smell recently? Yes/No
6. Have you had an itchy nose, sneezing, runny nose, congestion or postnasal drip? Yes/No
7. Have you experienced an increase in eczema, hives, or itching of the skin in the past week? Yes/No
8. Are you on any new medications? Any new eye drops? Yes/No

Please specify._____

9. Have you tested positive to COVID-19 within the past month? Yes/No
10. Have you had any recent exposure to anyone who has tested positive to COVID-19 within the past month? Yes/No

Medical Staff Intervention: Temperature:_____ degrees F

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