FOXHALL
INTERNISTS, PC

Date _____

We are now required to document the answers to the questions below for all patients we see in our office. Kindly complete this form in advance of your appointment and bring it with you.

Name _____ Date of birth _____

1. Have you received 2 doses of the Moderna or Pfizer COVID-19 vaccines, or one dose of the Johnson & Johnson COVID-19 vaccine, at least 2 weeks ago?

   ☐ Yes ☐ No

2. Within the past month, have you or a member of your household had a positive test for COVID-19, or are you/they currently waiting for test results?

   ☐ Yes ☐ No

3. Within the past 14 days, have you or a member of your household experienced any symptoms potentially due to COVID-19? A full list of symptoms is available on the CDC website here: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.

   ☐ Yes ☐ No

4. Within the past 14 days, have you or a member of your household had contact with an individual with a confirmed case of COVID-19?

   ☐ Yes ☐ No

Signature _____