West Milford Vision Center

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COVID-19 PANDEMIC – PATIENT DISCLOSURES

This patient disclosure forms seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense of taste or smell?		
Do you have a sore throat?		
Do you have chills?		
Are you experiencing muscle pain		
Are you fatigued		
Have you experienced vomiting		
Have you had diarrhea		
Have you been out of the state or country within the last 14 days, if so where and when did you return?		
Have you been diagnosed with COVID-19		
If yes, when		
How long have you been symptom free?		
Has anyone in your household been diagnosed with COVID-19		
If yes, when		
How long have they been symptom free?		

If you are experiencing any of these life-threatening symptoms, see your primary care doctor immediately:

- Bluish lips or face
- Severe and constant pain or pressure in the chest
- Extreme difficulty breathing (such as gasping for air or being unable to talk without catching your breath)
- Severe and constant dizziness or lightheadedness
- New serious disorientation (acting confused)
- Unconscious or difficulty to waking up
- Slurred speech or difficulty speaking (new or worsening)
- Seizures
- Signs of low blood pressure (too weak to stand, light-headed, feeling cold, pale, clammy skin)

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature   Date