**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer the following for today’s visit:**

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: Yes / No

(If yes, ready to quit?) Yes / No

Electronic Cigarettes/Vape: Yes / No

Flu Shot: Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age 65 or older:**

History of falling in last 3 months Yes / No

Impaired Judgement Yes / No

Agitation Yes / No

Impaired Walking/Shuffle Yes / No

Experienced vertigo/dizziness Yes / No

Ever soiled or wet self going to bathroom Yes / No

Pneumonia Vaccine: Yes / No Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent travel history**:

Yourself Family Member/Household

\_\_\_ None \_\_\_ None

\_\_\_ Last 7 days \_\_\_ Last 7 days

\_\_\_ Last 14 days \_\_\_ Last 14 days

\_\_\_ Last 21 days \_\_\_ Last 21 days

**Other Exposure**:

\_\_\_ Community exposure to Covid-19 last 14 days

\_\_\_ Healthcare exposure within last 14 days

\_\_\_ Exposure to respiratory illness of unknow etiology

\_\_\_ Unknown

**Covid 19 Status**:

\_\_\_ Positive Covid test in last 30 days

\_\_\_ Positive Covid test greater than 30 days ago

\_\_\_ No positive Covid test

\_\_\_ No Covid test performed