Name (please print): _____ Date: _____

Pre-injection Health Status Survey

(You MUST bring this completed survey to your appointment and give to the nurse.)

Temperature: _____ Peak Flow (Patients with asthma): _____ Antihistamine taken (Time): _____

COVID-19 Symptom Survey

COVID-19 affects different people in different ways. Infected people have had a wide range of symptoms reported – from mild symptoms to severe illness. Speak with your doctor if you have any symptoms listed below.

Symptoms that may appear 2-14 days after exposure to the virus:

- Cough
- Shortness of breath or difficulty breathing
- Diarrhea

Or at least two of the following:

- Fever
- Chills
- Repeated shaking with chills
- Muscle pain, Fatigue
- Headache
- Sore throat
- New loss of taste or smell

If you or anyone in your household has experienced any of these symptoms or has come in contact with anyone with any of these symptoms, has been diagnosed with COVID-19, or is under self-quarantine because of COVID-19 please contact your physician prior to your appointment to receive injections.

COVID-19 Symptoms present: None Yes: _____ Please speak with your doctor.

Pre-injection survey:

YES NO A) Feeling well today?

YES NO B) Any increase in allergy or asthma symptoms, or in albuterol use in the last week?

YES NO C) Any **local** reaction (redness, swelling, itching) after your last injections?

YES NO D) Any **generalized** reactions (sneezing, runny nose, coughing, congestion, tightness in your chest, trouble breathing, tickling of ears/nose/throat) after your last injections?

YES NO E) Any changes in medications?

I attest that the above information is true and correct to the best of my knowledge and that I agree to wait the required 30 minutes after my injections.

Signed:_____

PLEASE call our office with any questions or concerns.

Highland Park 847-433-7660 Barrington 847-382-2050 Arlington Hts. 847-392-0400