

Covid-19 Health Check

Due to COVID-19 we ask that you kindly complete and sign this form prior to your appointment and return it to us via email to info@gdconline.co.uk or by mail to **58 Lisburn Road, Belfast BT9 6AF**.

Unfortunately we will not be able to accommodate your appointment without having received this form.

If you are experiencing any COVID-19 symptoms, we ask that you do not come for treatment at this time. Symptoms include: a cough, shortness of breath, or difficulty breathing or any two of the following: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell; bear in mind this list is not all inclusive.

1. Have you travelled anywhere recently that are locations of disease outbreak? Yes ☐ No ☐
2. Have you attended any large group functions? Yes ☐ No ☐
3. Have you had any of the following symptoms within the last two weeks: fever, fatigue, dry cough, altered taste, altered smell, trouble breathing, productive cough (mucous in cough), or muscle pain? Yes ☐ No ☐
4. Have you previously had the SARS-COV-2 virus (COVID-19)? Yes ☐ No ☐
5. If, YES, did you test positive? Yes ☐ No ☐
6. What test were you administered?
7. Please tick any of the following which relate to you:

<input type="checkbox"/> Over the age of 65	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immunocompromised	
<input type="checkbox"/> Chronic lung disease inc. COPD	<input type="checkbox"/> Chronic kidney or liver disease	
8. If you have been vaccinated for COVID-19 please provide date(s) and place of vaccination.
(please email a copy of your test result)

Date of 1st Dose	<input type="text"/>	Date of 2nd Dose	<input type="text"/>
Place	<input type="text"/>		

First Name _____ Last Name _____ Date of Birth _____
(dd/mm/yyyy)

Signed _____ Today's Date _____
(dd/mm/yyyy)

Thank you for your understanding and we will contact you if we need further information. This confidential record will be added to your patient file.