Village Eye Care, P.C.
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STEVEN A. MARKOW, O.D., F.A.A.O., Doctor of Optometry

COVID – 19 Patient Disclosure Form

Name: _____

The safety of our patients, staff, and their respective families are of our upmost priority.

Due to the fact the Covid 19 vaccines and masks ARE NOT 100% effective and NOT everyone is able to receive the vaccine, we are screening ALL persons entering our office for the foreseeable future.

This disclosure form seeks information from you that we must consider before making treatment decisions with respect to the COVID-19 virus.

It is also important that we disclose to you if we (Dr. Markow and Staff) have any indications of having been exposed to COVID-19, or experience any signs of symptoms associated with the COVID-19 virus.

Please Circle

YES NO Have you received your COVID 19 Vaccine? **(If yes, When?)**
1st Dose_____ 2nd Dose_____

YES NO Do you have any fever or above normal temperature?

YES NO Do you experience any shortness of breath, or had any trouble breathing?

YES NO Do you have a dry cough or a runny nose (not associated to seasonal allergy)?

YES NO Have you recently lost or had a reduction in you sense of smell or taste?

YES NO Do you have a sore throat, nausea, vomiting, or diarrhea?

YES NO Have you been in contact with anyone who has tested Positive for COVID-19?

YES NO Have you been tested positive for COVID-19? ***If Yes, When?*** _____

YES NO Have you had a COVID-19 test and are waiting for results?

YES NO Have you traveled outside Massachusetts, or the US in the last 14 days?

List locations:_____

YES NO Have you been participating in large public gatherings?

Please sign: _____ Date:_____

Please sign: _____ Date:_____