## ARIZONA REPRODUCTIVE MEDICINE SPECIALISTS

**Patient _________________________ DOB_________________ Donor # _____________**

**Photo Identification: ________________________________________________________**

**COVID-19 questions:**

1. Have you had a medical diagnosis of COVID-19 infection in the past 28 days?

_______ NO _______ YES

2. Have you lived in or traveled to a Level 3 area of COVID-19 transmission within past 28 days?

(CDC COVID-19 Level 3 Country Designations reviewed with patient: https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html)

_______ NO _______ YES

2.A. If so where and when? ___________________________________________________

3. Have you had a fever or a severe respiratory illness, not otherwise explained or demonstrated to be COVID-10 NEGATIVE.

_______ NO _______ YES

4. Have you had a confirmed infection or received the designation of a Person under Investigation as defined by the CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html

5. Have you had any close contact with a confirmed COVID-19 defined as:
a) being within approximately 6 feet of a COVID-19 case for a prolonged period of time such as caring for, living with, visiting, or sharing a health care waiting area or room; or
b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)?

_______ NO _______ YES

Authorized person completing form:

Print ________________________________________ Date ____________________

Signature ________________________________________ Date ____________________