Taking Control of Your Immunity

Last Name (2): _____ First Name (2): _____

DOB: _____ Date of Service: _____ Tested Positive? ☐ Symptomatic? ☐

Symptoms: Mild? ☐ Moderate? ☐ Severe? ☐

Hospitalized? ☐ Long Haul Covid? ☐ Antibodies Confirmed? ☐

Year and Month of Infection: _____

Number of Hospitalizations in Household: _____

Number of Deaths in Household: _____

Clinic ID: DePice19090 Patient ID: _____

Team Initials: _____

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