# Risk Questionnaire for COVID-19 Vaccines

**Last Name (Please print)**

**First Name**

**MI**

**WID#**

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Date of Birth</th>
<th>Age</th>
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## 1. Are you 18 years of age or older?  
Yes | No |

## 2. Are you employed in a faculty, staff or on-campus student worker position?  
Yes | No |

## 3. Do you have any of the following medical conditions?  
- cancer  
- chronic kidney disease  
- chronic obstructive pulmonary disease (COPD)  
- down syndrome  
- heart conditions (ie. cardiomyopathy, heart failure (coronary artery disease))  
- immunocompromised state from a solid organ transplant  
- type 2 diabetes mellitus  
- sickle cell disease  
- pregnancy  
Yes | No |

## 4. Do you have any of the following medical conditions?  
- asthma (moderate-to-severe)  
- cerebrovascular disease  
- cystic fibrosis  
- hypertension  
- neurological conditions  
- liver disease  
- pulmonary fibrosis  
- thalassemia  
- type 1 diabetes mellitus  
- obesity (Body Mass Index (BMI) >30)  
- immunocompromised state (from blood or bone marrow transplant, immune deficiencies, HIV, use of chronic corticosteroid medication or other immune weakening meds)  
Yes | No |