COVID-19 Screening

Name:_____

Please complete this form in an honest and thoughtful manner. If you are at higher risk, we may postpone your operation/consultation, or utilize different strategies to maximize your safety.

Please answer each question by checking the box YES or NO.

Yes	No	
☐	☐	Have you traveled, or have you had close contact with someone, who has traveled within the past 14 days by plane or train.
☐	☐	Have you had close proximity > 5 minutes to a lab-proven COVID-19-positive or Person Under Investigation within the last 14 days?
☐	☐	Has anyone in your family or close work associates had confirmed, possible or suspected COVID-19 in the last 14 days?
☐	☐	Do you work in a higher-risk occupation, such as health care worker, first responder, front-line service worker, or grocery store/airline/worker?

Do you have any of the following Symptoms:

YES	NO	
☐	☐	Fever (100.0°F)
☐	☐	Shortness of Breath, cough or other respiratory symptoms
☐	☐	Muscle aches/pain
☐	☐	GI symptoms (nausea, vomiting, diarrhea)
☐	☐	Loss of appetite
☐	☐	Loss of taste or smell
☐	☐	Conjunctivitis
☐	☐	Chills / repeated shaking with chills
☐	☐	Extreme fatigue

Signature: _____ Date: _____

Remember: Please wear your Face Masks during your visit.