COVID-19 PATIENT HEALTH SCREENING FORM

Please take a moment to fill out your Covid-19 Patient Health Screening Form. A new form is required for every appointment with us until further notice.

First and Last Name _____

Date of Birth _____ Appointment Date _____

In the past 14 days, have you traveled to a foreign country or been in close contact (within 6 feet) with a person who has returned from a foreign country within the past 14 days?

- ☐ Yes
- ☐ No

In the past 14 days, have you traveled outside of your hometown within the United States without following the recommendations or guidelines to prevent and control the spread of Coronavirus infection as established by the applicable authorities in the area in which you were traveling (e.g., wearing personal protective equipment such as facemasks and/or adhering to social distancing standards)?

- ☐ Yes
- ☐ No

Do you currently have (or have you had in the past 14 days) any of the following symptoms: Fever, Chills, Cough, Headache, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Shortness of Breath or Difficulty Breathing, Loss of Smell or Taste, Unusual Fatigue, Diarrhea, Muscle or Body Aches?

- ☐ Yes
- ☐ No

In the past 14 days, have you been in contact (within six feet) of a person with possible Coronavirus or have you tested positive for Coronavirus (COVID-19)?

- ☐ Yes
- ☐ No

☐ **By checking this box and signing below, I affirm and certify that all the information and answers to questions herein are complete, true and correct to the best of my knowledge and belief.**

Signature _____ Todays Date _____