COVID-19 Screening Questionnaire

Patient Name _____ Date of Birth _____

Procedure Date _____

The safety of our employees, patients, and visitors remains our top priority. To prevent the spread of COVID-19 and reduce the potential risk of exposure to everyone, we request that you complete this questionnaire.

You will need to take your temperature for seven days prior to your procedure:

1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____

Have you ever tested positive for COVID-19? □ Yes □ No

Are you awaiting results of COVID-19 testing? □ Yes □ No

Have you been in close contact with anyone suspected or known to have COVID-19 in the last 14 days?
□ Yes □ No

Have you traveled anywhere outside the United States or traveled by cruise ship in the last 14 days?
□ Yes □ No If so, where did you travel? _____

Have you had any of the following symptoms in the last 14 days? □ Yes □ No

□ Fever □ Loss of smell or taste □ Diarrhea

□ Muscle pain □ Sore throat □ Persistent cough

□ Rash on palms of hands or soles of feet □ Conjuctivitis

Contact your physician if you have or have had any of these symptoms in the last 14 days

Please wear a mask when entering the building.

The responsible adult driving you home must wait in the car, go home, or run errands, etc. We will call them when you are ready to be discharged.