Covid-19 Screening Question

Because we are trying to keep our patients and staff as safe as possible we are asking all patients to print out this form, answer each question and sign at bottom. Please bring filled out form to your appointment.

Yes	No	Question
		Are you experiencing a new cough (in the last few days)?
		Are you experiencing a fever or chills?
		Are you experiencing new muscle aches (in the last few days)?
		Are you experiencing new shortness of breath (in the last few days)?
		Are you experiencing a new sore throat (in the last few days)?
		Are you experiencing a loss of smell or taste?
		Have you tested positive for Covid-19 and if so, how long ago ______________?
		Have you been in contact with anyone else who has tested positive for Covid-19 and if so how recent ___________________?

If you answer yes to any of the above or have been exposed/tested positive in the last 2 weeks, we ask you to reschedule to a later date when symptom free and are past the 2 week window if positive or exposed.

Name: ________________________________ Date: ___________