Pre- Appointment Screening (2 Days Before Appointment)

Patient Name: _______________________________ Date of Birth: __________________________

Appointment Date: __________________ Appointment Time: _______________________________

Have you tested positive for COVID-19 in the past 30 days?

☐ No ☐ Yes

Have you had a suspected case of COVID-19 in the past 30 days or are waiting for results of a COVID-19 test?

☐ No ☐ Yes

In the past 14 days, have you been in close contact with a person with a suspected or confirmed case of COVID-19 or a person who is waiting for results of a COVID-19 test?

☐ No ☐ Yes

Have you had a fever in the past 14 days?

☐ No ☐ Yes

Are you currently taking Tylenol or NSAIDS (Ibuprofen, Aleve, etc.)

☐ No ☐ Yes

Have you had any symptoms in the past 14 days?

☐ Coughing ☐ Shortness of breath/difficulty breathing

☐ Chills ☐ Repeated shaking with chills

☐ Muscle Pain ☐ Headache

☐ Sore throat ☐ New loss of taste or smell

☐ Other Symptoms: _________ ☐ None of the Above

________________________________ ________________

Responsible Party, Signature **Date**