Patient Questionnaire

The safety of our patients, employees, families and visitors are a priority. To prevent the spread of COVID-19 and reduce the potential risk of exposure, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

Name: _____

Date of Birth: _____/_____/_____

Phone Number: _____Today's Date: _____/_____/_____

Patient Self-Declaration

1. Have you returned from traveling outside of the United States within the last 14 days?

   Yes ☐ No ☐

2. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?

   Yes ☐ No ☐

3. Have you been in close contact with anyone who has traveled outside of the United States within the last 14 days?

   Yes ☐ No ☐

4. Have you experienced any of the following cold or flu-like symptoms in the last 14 days?

   Fever Yes ☐ No ☐

   Cough Yes ☐ No ☐

   Sore Throat Yes ☐ No ☐

   Shortness of Breath Yes ☐ No ☐

Signature: _____ Date: _____