PATIENT PRE-SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

Have you traveled outside the U.S. in the past 30 days?  YES  NO

If yes, where? ___________________________

Have you traveled to a U.S. City/State with reported cases of Coronavirus in the past 30 days?  YES  NO

If yes, where? ___________________________

Have you been in personal contact with a person infected with Coronavirus or who has traveled to an area with widespread and ongoing transmission of Coronavirus in the past 30 days?  YES  NO

IN THE LAST 48 HOURS:

Have you had a fever (99.5°+)?  YES  NO

Have you experienced any:

  Coughing?    YES  NO

  Sore Throat?  YES  NO

  Difficulty Breathing?  YES  NO

  Muscle Aches?  YES  NO

  Stomach Pain?  YES  NO

Print Name: ___________________________________________________________

Signature: ____________________________________   Date: _________________

**Please return this form to the front desk when completed**