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*****