Name: Today's Date:

1. *Have you experienced any symptoms of fever?
   Yes ☐ No ☐
2. *Do you have shortness of breath or symptoms of a respiratory infection?
   Yes ☐ No☐
3. Have you recently lost your sense of taste and/or smell?
   Yes☐ No☐
4. *Have you traveled within the last 14 days?
   Yes ☐ No ☐ If so, Where?
5. *Have you been in contact with someone with known or suspected COVID-19?
   Yes☐ No☐
6. *Are you currently waiting for the results of a COVID19 test?
   Yes ☐ No☐

If you answered yes to any of these questions, we will have to reschedule your appointment in two (2) weeks.

I have answered these questions truthfully to the best of my knowledge to prevent the spread of COVID19, for the safety of myself, other patients, as well as the staff.

Signature:_____
Date:_____