

Name: Today’s Date:

1. \*Have you experienced any symptoms of fever?

 Yes No 

1. \*Do you have shortness of breath or symptoms of a respiratory infection?

 Yes  No

1. Have you recently lost your sense of taste and/or smell?

 YesNo

1. \*Have you traveled within the last 14 days?

 Yes No  If so, Where?

1. \*Have you been in contact with someone with known or suspected COVID-19?

 YesNo

1. \*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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_