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COVID-19 SCREENING FORM

As a means of protecting our patients and staff-we are screening all our patients prior to admission to the clinic. Please complete, sign and date the following screening questionnaire prior to your appointment.

Thank you so much for your cooperation!

PLEASE ANSWER ALL QUESTIONS:

1. Have you or a member of your household traveled by air in the last 14 days?
Yes _____
No _____
2. Do you have any of the following symptoms: fever/feverish, sore throat, new or existing cough, new onset shortness of breath?
Yes _____
No _____
3. Have you had close contact with a confirmed or probable COVID-19 case?
Yes _____
No _____
4. Have you had close contact with a person with acute respiratory illness in the last 14 days?
Yes _____
No _____
5. Have you worked in a facility with confirmed COVID-19 Cases?
Yes _____
No _____

Signature: _____ **Date:** _____

YOUR HEARING MATTERS