# COVID-19 Screening Form

If you have been exposed to a communicable disease, you may spread the disease to the practitioner, staff, or other patients/visitors in the practice. Therefore, prior to each appointment, we will be asking the following questions to reduce the chances of transmission and ensure the safety of the practice and its visitors

Select whichever apply to you *

- [ ] I have not received any doses of any COVID-19 vaccinations.
- [ ] I have received my first dose of the Johnson & Johnson vaccine.
- [ ] I have received a booster dose of the Johnson & Johnson vaccine.
- [ ] I have received my first dose of the Moderna or Pfizer vaccine.
- [ ] I have received my second dose of the Moderna or Pfizer vaccine.
- [ ] I have received a booster dose of the Moderna or Pfizer vaccine.

Please write the date of your last COVID-19 vaccine dose. If none, enter, "N/A" *

Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days? *

Yes No

Have you or others in your household traveled outside of the state within the past 14 days? *

Yes No

Has someone accompanying you to your appointment or anyone in their household traveled outside of the state in the last 14 days?

Yes No

If "Yes" where did you/they travel?

Have you been tested for COVID-19 in the last 14 days? *

No
Yes, tested positive
Yes, tested negative
Yes, no results yet

Do you, others accompanying you today, or anyone you or they have been in contact with within the last 14 days have any of the following novel symptoms (not due to a pre-existing condition such as chronic fatigue syndrome or asthma)?

Fever (defined as above 100.4° F degrees)? *

Yes No

Chills or repeated shaking with chills? *

Yes No

Cough? *

Yes No

Sore throat? *

Yes No

New loss of taste or smell? *

Yes No

Shortness of breath or having trouble breathing? *

Yes No

Headache? *

Yes No

Body aches? *

Yes No

Nasal congestion?

Yes No

Fatigue/malaise?

Yes No

Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days? *

Yes No

If you selected YES to any of the questions above provide the approximate dates of the symptoms

Start Date

End Date

Agree & Acknowledge

- I understand that if I answer yes to any of these questions I may be asked to reschedule my appointment to a later date.
- I agree to notify the clinic if I become ill with COVID-19 symptoms or test positive for COVID-19 within 14 days of my appointment.
- I understand the clinic has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days of my appointment.
- By signing, I assert that the above are true and correct to the best of my knowledge.
- By signing, I agree to wear a well-fitted face mask over my nose and mouth for the duration of my appointment. Masks should always have multiple layers if made of fabric. Ideally, masks should include at least one layer of non-woven material (e.g. a surgical mask under a fitted cloth mask; a cloth mask with a non-woven filter; a KN95 or an N95 mask). Masks should not have vents.

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*Draw your signature*

Type It Draw It Clear