

**RECEIVING MEDICAL TREATMENT DURING THE COVID-19 PANDEMIC**

You have come to our office today for a routine medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our office complies with State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.
- In order to reduce the risk of spreading COVID-19, we have asked you a number of “screening” questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY

DATE

**PLEASE CHECK “YES” OR “NO” FOR THE FOLLOWING QUESTIONS:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. HAVE YOU BEEN EXPOSED TO ANYONE WHO HAS BEEN DIAGNOSED WITH COVID-19 IN THE PAST 21 DAYS?                            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. DO YOU HAVE A FEVER?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 5. DO YOU HAVE ANY SHORTNESS OF BREATH?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 6. DO YOU HAVE A DRY COUGH?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. DO YOU HAVE A RUNNY NOSE?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. DO YOU HAVE A SORE THROAT?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. HAVE YOU EXPERIENCED HEADACHES, FATIGUE, OR WEAKNESS?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 11. HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |