COVID-19 Acknowledgement & Screening Form

Patient Name _____

In order to reduce the risk of spreading COVID-19, we would like for you to answer the following screening questions below. For the safety of our staff, patients, and yourself, please be truthful and candid in your answers. Thank you for your understanding during this time.

1. Have you or any member of your household traveled outside of Illinois in the last 14 days?

Yes _____ No _____

A. If yes, where?

_____

2. Have you come into close contact with a person diagnosed (laboratory confirmed) with COVID-19 (Coronavirus) within the past 14 days?

Yes _____ No _____

3. Have you experienced flu like symptoms or any of the following (including but not limited to):

- Shortness of breath Yes _____ No _____
- Dry Cough Yes _____ No _____
- Fever greater than 100°F Yes _____ No _____
- Difficulty breathing Yes _____ No ____
- Loss of Taste/Smell Yes _____ No ____

If you answer yes to any of these questions, please reschedule your appointment.

Signature _____ Date _____