To best protect our staff, patients, and community, please fill out the following form to be reviewed for your appointment today.

Do you have any of the following symptoms?	**YES**	**NO**
COUGH		
SHORTNESS OF BREATH		
FEVER		
CHILLS/SHAKING		
FATIGUED/ RUN DOWN		
HEADACHE		
LOSS OF TASTE OR SMELL		
SORE THROAT		
MUSCLE ACHES/PAINS		

Have you been exposed to a COVID-19 positive patient? And if yes, when?

____

____

Is anyone in your family ill? **NO** ______________ **YES**_________________ Please explain

____

Print Patient Name ____

Patient Signature (or Parent/Guardian) __________________________________Date _________________

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