COVID-19 PATIENT SCREENING FORM

Dear Esteemed Patient,

Thank you for choosing our office for your upcoming appointment. As we continue to navigate the challenges posed by the COVID-19 pandemic, your health and safety, along with that of our staff and community, remain our utmost priority.

Kindly take a moment to complete this unique screening form before your scheduled visit. We require this information to ensure a safe environment for everyone involved. Please send the completed form to us via email at (office email address) prior to your appointment. Your cooperation in this matter is greatly appreciated.

For the protection of all individuals, we kindly request that you wear a face mask upon arrival at our office. If you do not have one, we will be pleased to provide you with a fresh face mask, contingent upon the availability of our PPE supply.

Please refrain from visiting our office if you are experiencing any symptoms related to COVID-19. These symptoms may include but are not limited to:

- Cough, shortness of breath, or difficulty breathing
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell

If you exhibit any of the following warning signs, we advise seeking emergency medical attention promptly:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion or inability to arouse
- Bluish lips or face

In case you are unable to print and email this form, please copy and paste the questionnaire into the body of a composed email and send it to the aforementioned email address.

PATIENT QUESTIONNAIRE

Have you traveled to any regions affected by disease outbreaks recently?
Have you come into contact with anyone displaying symptoms of illness?
Have you attended any gatherings or events with a large number of people?
Within the last two weeks, have you experienced any of the following symptoms: fever, fatigue, dry cough, changes in taste or smell, difficulty breathing, productive cough, or muscle pain?
Have you previously tested positive for the SARS-CoV-2 virus (novel coronavirus)? If so, what type of test did you undergo?
Are you 65 years of age or older and/or do you have preexisting health conditions such as diabetes, chronic lung disease or asthma, serious heart conditions, compromised immune system, or chronic kidney or liver disease?

We sincerely appreciate your cooperation in completing this form. Rest assured, all information provided will be handled with the utmost confidentiality.

Thank you for your understanding and assistance in maintaining a safe environment for all.

Warm regards,

Dr. [Your Name]