FILL YOUR FACE AESTHETICS
ageing is optional

COVID-19 PRE-APPOINTMENT WELLNESS SCREENING CHECKLIST

CLIENT NAME_____ DOB_____

SYMPTOM CHECK:

1. Have you experienced ANY of the following symptoms within the last 14 days?

- Temperature or feeling feverish YES □ NO □
- New cough YES □ NO □
- Sore throat YES □ NO □
- Shortness of breath YES □ NO □
- Flu-like symptoms such as fatigue, headache YES □ NO □
- Nausea or Diarrhoea YES □ NO □
- Chills or shivering YES □ NO □
- Muscle pains or rash YES □ NO □
- Loss of taste OR smell YES □ NO □

2. Have you been diagnosed or suspected of having COVID-19? YES □ NO □

Have you had a throat and nasal swab? YES □ NO □
Did you test Positive or Negative? _____Date of Test_____

Have you had an antibody blood test? YES □ NO □
Was it Positive or Negative? _____ Date of Test _____

FAMILY AND CLOSE CONTACTS:

Are any of your family members or immediate/close contacts currently sick or experiencing:

- Fever, Cough, Shortness of breath or Flu-like symptoms? YES □ NO □
- Sore throat, Muscle aches, Fatigue, Nausea & Diarrhoea? YES □ NO □

2. Have any of your family members or immediate/close contacts been diagnosed with COVID-19? If yes, when? _____

RECENT TRAVEL:

1. Have you travelled internationally, travelled within the UK or attended a public event in the last 15 days?

If yes, where and when? _____

2. Has any of your family or close contacts travelled internationally, travelled within UK or attended an event in the last 15 days?

If yes, where and when? _____

CLIENT NAME (PRINT) _____

SIGNATURE: _____ DATE _____