Wellness and Aesthetics, LLC

COVID 19 Screening questionnaire: Have you had any of the following symptoms in the last 2-14 days:

1. Fever or chills
2. Cough, shortness of breath or difficulty breathing
3. Fatigue
4. Muscle or body aches
5. Headache
6. New loss of taste or smell
7. Sore throat
8. Congestion or runny nose
9. Nausea or vomiting
10. Diarrhea
11. Have you traveled out of the state in the last 14 days?
12. Have you been exposed to someone who has tested positive for COVID-19?

If any of these symptoms are positive, please provide an explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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You may be asked to reschedule your appointment or done virtually.

Please be aware that we are taking all precautions to mitigate risk of exposure to COVID-19.

\*A Telehealth visit is an option if you prefer. Please let me know.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_