**COVID-19 SCREENING**

Do you have fever or above normal temperature?

 Yes [ ] No [ ]

Have you experienced shortness of breath or had trouble breathing?

Yes [ ] No [ ]

Do you have a dry cough?

Yes [ ] No [ ]

Do you have a runny nose?

Yes [ ] No [ ]

Have you recently lost or had a reduction in your sense of smell?

Yes [ ] No [ ]

Do you have a sore throat?

Yes [ ] No [ ]

Have you tested positive for Covid-19?

Yes [ ] No [ ]

Have you been tested for Covid-19 and are waiting for test results?

Yes [ ] No [ ]

Have you traveled outside the U.S. by air or cruise ship since January 2020?

Yes [ ] No [ ]

To the best of your knowledge, have you had contact with anyone that has tested positive for Covid-19?

 Yes [ ] No [ ]

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge the answers I have provided are true and accurate.

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