Name _____ Date _____

ILLNESS SCREENING

Please print this page, check “YES” or “NO” to each question, and bring with you to your eye exam appointment!

1) Have you been diagnosed with or suspected to have COVID-19 in the past 2 months? ☐ **YES** ☐ **NO**
2) Have you been in direct contact with someone who was confirmed or suspected to have COVID-19 in the past 2 months? ☐ **YES** ☐ **NO**
3) Do you have any flu-like symptoms, including fatigue, aches, chills, sore throat, or fever? ☐ **YES** ☐ **NO**
4) Do you have a cough or are you feeling short of breath? ☐ **YES** ☐ **NO**
5) Have you had a new headache recently? ☐ **YES** ☐ **NO**
6) Have you lost your sense of smell and/or taste recently? ☐ **YES** ☐ **NO**
7) Do you have any new onset eye irritation (where one or both eyes have been irritated, watery, red, painful, and/or sensitive)? ☐ **YES** ☐ **NO**

IMPORTANT: If you answered “YES” to ANY of the above, please notify us ASAP and PRIOR to your appointment, as we may have further questions to ask of you.

Again, please don’t forget to bring your **unvalved mask** with you! We appreciate that you have agreed to show up to your appointment **without any guests**.

Thank you for your understanding during this time.