COVID-19 PRE-SCREENING QUESTIONNAIRE

1. Have you travelled internationally in the last 14 days?
2. Have you experienced a loss of taste or smell?
3. Do you have a cold, cough, or flu or recently recovered from having a cold or the flu?
4. Have you been in contact or cared for anyone who is sick with a communicable virus?
5. Have you experienced a sudden shortness of breath or any difficulty breathing?
6. Do you have muscle pains, shaking, chills, nausea, or fever?
7. Do you have a headache or sore throat?
8. Do you have an upset stomach, cramping, nausea or diarrhea?
9. Have you been in contact with ANYONE who has tested positive or negative for **COVID-19?**
10. Have you been asked by a Medical Doctor to QUARANTINE due to **COVID-19** in the last 14 days?
11. Have you tested positive or negative for **COVID-19** in the last 30 days?

PATIENT SIGNATURE

I, Patient, have answered the above Pre-Screening questions that are true and acurate to the best of my ability. I understand that my treatment or service could be denied by **SKINfinity LLC** for not disclosing information that is known to me; or for reasons that are determined by **SKINfinity LLC** to be a health risk to others on the day of my appointment. As a patient; I consent to the Pre-screening questionnaire and the safety measures that SKINfinity LLC has adopted to minimize the risk of all communicable viruses; including **COVID-19.** In the event my medical history should change; I agree without fail to notify **SKINfinity LLC** prior to receiving any treatment of services.

PATIENT SIGNATURE: ____________________________________ **DATE**:_________________

WITNESSED BY SKINfinity LLC: ____________________________________ **DATE**:_________________

Additional Comments:

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