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 flu?
4. Have you been in contact or cared for anyone who is ill with a communicable virus?
5. Have you experienced a recent shortness of breath or 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 to **SKINfinity, LLC** that is true and acurate to the best of my ability. I understand that my treatment or service could be denied for not disclosing accurate information to **SKINfinity LLC** that is known to me; or considered by **SKINfinity LLC** to be a potential risk for a communicable virus; including **COVID-19.** As a patient; I consent to notify **SKINfinity, LLC** without fail if my medical record or part of this PRE-SCREENING QUESTIONNAIRE has changed prior to receiving any services or treatments at **SKINfinity LLC**.

[The section below is completed by a Staff Member at the time of Check-in & Pre-Screening]

PATIENT SIGNATURE: _____ DATE:_____

STAFF INITIALS:_____

ADDITIONAL COMMENTS