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Safety& Wellness Screening Form

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____ (Preferred Name)

Please accept the following responsibilities to safeguard those around you:

1. Arrive at the office wearing a face covering
2. Sanitize your hands
3. Have your temperature taken
4. Reschedule if you are sick
5. Do not come into the office if you are experiencing any COVID -19 related symptoms.

ie., trouble breathing, persistent pain or pressure in the chest, new confusion or inability to arouse, bluish lips or face. Seek emergency care immediately.

Please answer the following questions:

A. Have you had any of the following symptoms within the last two weeks? *

- ☐ Dry cough
- ☐ Fever and/or chills
- ☐ Difficulty breathing
- ☐ Runny nose
- ☐ Sore throat
- ☐ Loss of taste or smell
- ☐ Headache
- ☐ None of these symptoms
- ☐ Shortness of breath
- ☐ Muscle pain

B. Please mark any of the following that apply to you: *

- ☐ I have previously been diagnosed with COVID- 19
- ☐ I think I had COVID - 19
- ☐ I think I have COVID - 19
- ☐ I had a positive nasal swab test
- ☐ I had a positive blood test.
- ☐ I had a positive saliva test
- ☐ None of the above

If yes to any of the tests or symptoms, then when were you confirmed positive? (Date) _____

Notes

_____

_____

C. If you have had COVID- 19, how were you confirmed negative:

- ☐ I was diagnosed negative by nasal swab test. (How many times and how far apart?)
- ☐ I show antibodies to COVID -19 with a blood test. (Which antibodies?)
- ☐ My doctor said I no longer have it because I do not have any symptoms. (Who is your doctor and what is his/her contact information?)
- ☐ I do not have any symptoms, so I do not have it.

Notes

_____

_____

D. Please mark any of the following that apply to you: *

- ☐ I have been in contact with someone who was sick.
- ☐ I have attended a large group function.
- ☐ I am over the age of 65.
- ☐ I have previously had the SARs-COV-2 virus (novel coronavirus)
- ☐ None of the above

E. Do you have pre-existing health conditions related to the following: *

- ☐ Diabetes
- ☐ Chronic lung disease or asthma
- ☐ Serious heart condition
- ☐ Immuno compromised
- ☐ Chronic kidney disease
- ☐ Liver disease
- ☐ None of the above

We thank you for your cooperation and we will contact you if we need further information.

☐ **I understand and agree that to provide and take the necessary steps to protect the health and safety of myself and all those who I come into contact with at this office, I will agree to do a safety and wellness check 24 hours betore each appointment, on the appointment day, the day after and 14 days following the appointment.**

The signature of the patient, parent, or guardian will be electronically signed at your appointment in the office.

If applicable, relationship to patient _____

Response Date: _____