Safety & Wellness Screening

Last name:_____
First name:_____MI:_____

Please accept the following responsibilities to safeguard those around you:

A. Do the following:

1. Arrive at our office wearing a face covering
2. Sanitize your hands
3. Have your temperature taken with a non contact thermometer

B. Answer the following:

1. Are you sick? ___yes ___no
2. Within the past two weeks have you had any of the following symptoms? (Mark all that apply)

___ Dry cough
___ Fever and/or chills
___ Shortness of breath or difficulty breathing
___ Fatigue
___ Muscle or body aches
___ Headache
___ New loss of taste or smell
___ Sore throat
___ Congestion or runny nose
___ Nausea or vomiting
___ Diarrhea
___ Persistent pain or pressure in the chest (Seek emergency care immediately)
___ New confusion or inability to arouse (Seek emergency care immediately)
___ Bluish lips or face (Seek emergency care immediately)

3. Within the last two weeks have you traveled more than 150 miles from this location?
___yes ___no
4. Have you been exposed to anyone who tested COVID positive? ___yes ___no
5. When did you last attend a large group function? _____
6. ___I am over the age of 65.
7. Do you have pre-existing health conditions related to the following?

___Diabetes
___Chronic kidney disease
___Chronic lung disease
___Liver disease
___Serious heart condition
___Immuno compromised

C. Please mark any of the following that apply:

___Previously I have been diagnosed with COVID-19
___I think/suspect I had COVID-19
___I think I have COVID-19
___I had a positive COVID blood test. If so, date: ____/_____/_____
___I had a positive COVID nasal swab test. If so, date: ____/_____/_____
___I had a positive COVID saliva test. If so, date: ____/_____/_____

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
A. 24 hours before each appointment;
B. on the appointment day;
C. the day after the appointment;
D. 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:_____