COVID-19 SCREENING QUESTIONNAIRE

This form will be updated in accordance with the CDC and California Department of Public Health information on COVID-19 continues to evolve.

Your health and well-being are of the upmost importance and we are taking measures to keep the office a safe environment for employees as well as our patients. Anyone visiting our office will be required to to through the screening process which includes answering this questionnaire, and have their temperature prior to entering our office. You will also be required to wear appropriate face covering and maintain a safe social distance of 6 feet or more.

1. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

2. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

3. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

4. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise?
   - ☐ YES
   - ☐ NO

5. Within the last 14-days, have you had a temperature at or above 100.4° or the sense of having a fever?
   - ☐ YES
   - ☐ NO

6. Within the last 14 days, have you had close contact, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19?* *(Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes)*
   - ☐ YES
   - ☐ NO

Please note, if you answer YES to any of the questions above you will not be allowed into the facility/office per CDC and California Public Health COVID-19 guidelines.

Name: _____ Date: _____

Staff Signature: _____ Time: _____ Date: _____