COVID-19 Questionnaire

These questions are intended to help preserve your health and safety as well as the health of fellow patients, our doctors, and staff. We appreciate your understanding.

YES	NO	
☐	☐	1. Have you traveled by air in the last 14 days?
☐	☐	2. Do you currently have a cough, fever, shortness of breath or respiratory condition?
☐	☐	3. In the last 14 days, have you tested positive or have a test pending for coronavirus (COVID-19)?
☐	☐	4. Have you been in close contact with anyone who has tested positive for coronavirus (COVID-19) in the last 14 days or who has a test pending?

_____ _____

Patient Name (Print) Patient Signature

_____

Date

☐ *By checking this box, I agree to today's evaluation.

Note: Prior to examination, a temperature measurement may be taken.

*From the American Optometric Association: Doctors of Optometry are frontline physician providers of essential care. Based on the immediate health needs of a patient, Doctors of Optometry can and should use their professional judgement to determine the timing and course of care.