COVID-19 WELLNESS FORM

Please read carefully and circle your answer.

1. Do you have a cough? Yes No
2. Do you have a fever now or have you in the past 14-21 days? Yes No
3. Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days? Yes No
4. Are you experiencing shortness of breath or difficulty breathing? Yes No
5. Are you experiencing flu-like symptoms, such as headache, fatigue or gastrointestinal upset? Yes No
6. Have you experienced recent loss of taste or smell? Yes No
7. Are you over the age of 60? Yes No
8. Do you have heart disease, lung disease, kidney disease diabetes or any auto-immune disorders? Yes No
9. Have you traveled in the past 14 days to any regions affected by COVID-19 (As relevant to your location) Yes No

I am aware that I am REQUIRED to wear a face mask for the duration of my appointment.

Signature: _____ Date: _____