Recent Health History

In light of recent world events and in order to protect the health of our patients and staff, please take a few moments to answer the following questions.

1. Do you have any symptoms of a respiratory infection (cough, sore throat, congestion,, shortness of breath) now or within the past week?	Yes	No
2. Do you have any symptoms of the stomach flu (nausea, vomiting, diarrhea) now or within the past week?	Yes	No
3. Have you had a fever or repeated temperatures over 99.5 degrees or any associated muscle aches/pain over the past week?	Yes	No
4. Have you been in contact with family members or people who are sick with a fever or respiratory infection?	Yes	No
5. Have you had confirmed or suspected contact with any individual diagnosed COVID-19 within the last 14 days?	Yes	No
6. Have you continued to work in/at an essential business during the last 30 days?	Yes	No
7. Have you practiced adequate social distancing in recent weeks?	Yes	No
8. Have you home quarantined for any extended period prior to this visit?	Yes	No
9. Have you used personal protective equipment when leaving your home?	Yes	No

Name: _____

Signature: _____

Date: _____