WELLNESS SCREENING

Patient Name: _______________________________ DOB: ____________________

Home Address: ____

Phone Number: ______________________________

Do you have or have had respiratory symptoms, dry cough, or fever within the last two weeks? **Yes** **No**

List symptoms:

____

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If yes, you will be reappointed; please consult with your medical doctor

- Have you traveled outside of the US or Northern California within the last three weeks? If so, where?

Yes, ___________________________

No

Within the last 2-3 weeks, have you been in close contact (less than 6 feet of social distancing) with a person known to have or suspected to have COVID-19?

Yes **No**

___________________________________ ________________________________

Signature of responsible party Date

___________________________________ ________________________________

Team member signature Date