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Visitor Screening Questionnaire

In effort to protect our patients and team from illness we are screening visitors. Please answer the following questions:

1. Within the past 14 days, I have traveled to a location where COVID-19has been diagnosed or suspected: Yes No
2. Within the past 14 days, I have been in close contact with persons who have traveled to a location where COVID-19 has been diagnosed or suspected: Yes No
3. Within the past 14 days, I have been sick with cold or flu like symptoms: Yes No
4. Within the last 7 days, I have had a fever: Yes No
5. Within the last 7 days, I have had a sore throat: Yes No
6. Within the last 7 days, I have had nausea and vomiting: Yes No
7. Within the last 7 days, I have had diarrhea: Yes No
8. I currently have cold or flu symptoms: Yes No
9. I currently have a fever: Yes No
10. Within the past 14 days, I have been around people who Who are currently sick with a cold or the flu: Yes No
11. Within the past 14 days, I have been around people who Were sick with colds or the flu: Yes No

IF YOU HAVE MARKED "YES" TO ANY OF THESE QUESTIONS, PLEASE POSTPONE YOUR VISIT FOR AT LEAST 14 DAYS FROM THE DAY YOUR SYMPTOMS BEGAN – THANK YOU FOR UNDERSTANDING

PRINT NAME: _____

SIGNATURE: _____ DATE: _____