CORONAVIRUS (COVID - 19) PATIENT SCREENING QUESTIONAIRE

Do you have a fever or respiratory symptoms such as cough, sore throat or difficulty breathing?

Yes or No

1. Is anyone in your household feeling sick with cough, cold, fever or shortness of breath?

Yes or No

2 . Have you (or your Immediate family) traveled outside of Michigan in the past 14 days?

Yes or No

3. Have you had fatigue, muscle aches, loss of taste or smell?

Yes or No

During the Co-Vid 19 pandemic our office is doing everything within our power to ensure a safe environment for both patients and staff with enhanced sanitation & screening protocols. Although, without on-site testing there is not a way to identify silent carries and with that comes risk to anyone outside of their own home.

Signature: _____ Date:_____

Print Name:_____