COVID-19 Patient Advisory and Screening

Patient Name ____

You are in our office today for medical evaluation or treatment done during the COVID-19 pandemic.

While our office complies with State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees about COVID-19 transmission during your visit to our facility.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce risk of spreading COVID-19, we are asking the screening questions below. For the safety of our staff, other patients, and you, please be truthful and candid in your answers.

Date											
Temperature ^{0}F											
Check ___ in column if YES											
Have you in the past 14 days											
Been tested for COVID-19											
Traveled outside of Illinois?											
Been exposed to a person with COVID-19?											
Have you had in the past 14 days unexplained:											
Fever (Temp > than 100.4^{0}F or 38.0^{0}C)											
Shortness of breath											
Dry cough											
Runny nose											
Sore throat											
Sneezing											
Headache, fatigue, weakness											
Loss of sense of taste or smell											
Staff initials											

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