Pre-Visit Covid Questionnaire

Please circle **YES** or **NO** for the following:

Are you experiencing any of the following symptoms: **fever, chills, cough, sore throat, trouble breathing, pain/tightness in chest or new loss of taste/smell**?	**Yes** or **No** If yes, please explain:
Have you (or others accompanying you today) traveled outside of our local area or outside of the US within the past 14 days?	**Yes** or **No** If yes, please explain:
Have you (or others accompanying you today) recently had a known exposure to COVID-19?	**Yes** or **No** If yes, please explain:
Have you ever tested positive for COVID-19?	**Yes** or **No** If yes, please provide date:
Have you been vaccinated for COVID-19?	**Yes** or **No** If yes, have you received both vaccinations? **Yes** or **No**

Print Name: ___________________________________**Sign Name:** ____________________ **Date:** __________