2020 EyeCare Center Optometry

COVID-19 Screening

Have you, your child, or others accompanying you to today's appointment tested positive for or been diagnosed as having COVID-19?

YES I NO If so, when? Date: _____

Have you, your child, or others accompanying you to today's appointment had exposure to anybody with a confirmed positive COVID-19 diagnosis?

YES I NO If so, when? Date: _____

Have you, your child, or others accompanying you to today's appointment have or have had within the prior two weeks:

- A Fever/ Chills YES I NO
- Cough YES I NO
- Shortness of breath or difficulty breathing YES I NO
- Diarrhea YES I NO
- Muscle Pain YES I NO
- Headache YES I NO
- Sore throat YES I NO
- New loss of taste or smell YES I NO
- History of travel YES I NO

Name:_____ Patients Temperature:_____

Signature:_____ Date:_____