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CORONVIRUS SAFETY SCREENING:

To all patients:
In the interest of patient and staff safety, we are asking patients to complete the following checklist before their appointment with their doctor.

1. Have you had either of the below symptoms with the past 48 hours?
   _____ Fever (38°C/100.4°F) _____ New Cough

   If YES to fever:
   When did the fever start?
   When was the last time you had a fever?
   Have you taken any medicine for the fever?
   If NO to fever:
   Have you taken any medicine that could surpress fever (e.g. aspirin, acetaminophen, ibuprofen, naproxen, etc.)?
   If YES to cough:
   When did the cough start?
   When did the cough end?

A. If YES: Please contact your primary care physician or visit an urgent care facility.

2. Have you been in contact with someone who has a fever and/or cough within the past 14 days?
   _____ YES _____ NO

   a. If YES: Please contact your primary care physician or visit an urgent care facility.

3. Have you been in contact with a confirmed COVID-19 patient within the past 14 days?
   _____ YES _____ NO

   a. If yes, please contact your primary care physician or visit an urgent care facility.

4. Have you or anyone you have had contact with experienced flu like symptoms?
   _____ YES _____NO

5. Have you or anyone you have had contact with travelled internationally within the past 14 days?
   _____ YES _____NO

6. Have you or any you have had contact with travelled outside of the DMV area to a known higher risk area? (i.e. Florida, New York, Washington State).
   _____ YES _____NO

If NO to all of the above questions, no further screening is needed.

Signature _____Date _____