SacEyeMD

COVID-19 (Coronavirus) Questions asked at initial screening:

Name:_____ **Date:**_____

Please circle the appropriate responses.

1. Do you currently have symptoms of a respiratory infection?
a. NO
b. YES. – If YES, please indicate your symptoms

Fever Shortness of breath. Cough. Sore throat. Loss of smell. Loss of taste

2. Do you currently have stomach-flu like symptoms or new onset fatigue?
a. NO
b. YES

3. Have you traveled outside this area (surrounding counties) within the past 14 days?
a. NO
b. YES – If YES, When? and Where?

4. Within the last 14 days, have you been exposed to someone who has tested positive or diagnosed with COVID-19?
a. NO
b. YES – If YES, When? and Where?

5. Have you been tested positive to COVID-19?
a. NO
b. YES

Patient who answers YES to any of the questions above will be asked to postpone the appointment and/or procedure. Phone consultation can be provided by the ophthalmologist if needed.

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Signature of patient or legal guardian