TOTAL EYECARE

To help protect our patients and staff against the spread of COVID-19, please answer the following questions:

	YES	NO
1. Have you or anyone in your household had a fever in the last three (3) days, respiratory symptoms (cough and shortness of breath), flu-like symptoms or have been in contact with anyone with a confirmed case of COVID-19?		
2. Other than healthcare professionals working in patient care, are you currently providing care for anyone who has been diagnosed with COVID-19, had a fever, cough, difficulty breathing or flu-like symptoms in the last 2 weeks?		
3. Have you traveled internationally in the last 2 weeks?		
4. Are you or anyone in your household under voluntary or involuntary quarantine in the last 2 weeks?		

Entering Temperature: ___________

If YES to any of the above, please allow us to re-schedule your appointment.

Patient Signature____ Date ____________________