Coronavirus Screening Questionnaire

Name_____ Chart # _____

Have you experienced a sudden onset of any of the following symptoms within the last 2 weeks? Check all that apply

_____ Fever	_____ Cough	_____ Shortness of Breath
_____ Loss of smell	_____ Fatigue	_____ Loss of taste
_____ Chest pressure	_____ Chest pain	_____ Difficulty breathing
_____ Stuffy nose	_____ Body aches	_____ Bluish lips or face
_____ Red eyes	_____ Sore throat	_____ Chills
_____ Headache	_____ Nausea	_____ Vomiting
_____ Diarrhea	_____ Loss of appetite	_____ Sudden confusion

_____ None of these

Have you or any member of your household traveled by bus, plane, train, or other mass transit systems in the last 2 weeks? _____ Yes _____ No

Have you or any member of your household traveled out of the country in the last 14 days?

_____ Yes _____ No

Do you believe that you or anyone in your household has been exposed to or in contact with anyone who has been diagnosed with or showing symptoms of COVID-19 within the last 10 days?

_____ Yes _____ No

Have you or any one in your household been previously diagnosed, tested positive for, or presumably had COVID-19? _____ Yes _____ No If yes, when _____

I have answered the above statements honestly and to the best of my knowledge. I understand that Canting Optometry is taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by 100%. I understand that there are risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result. I hereby release Canting Optometry from any responsibility should I or anyone I come in contact with become positive or presumably positive with COVID-19 after my visit. In addition, I understand that COVID-19 can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye health to be essential to the maintenance of my vision. Furthermore, I agree to contact Canting Optometry if I display any of the symptoms of COVID-19 within 14 days of my visit so that others may be contacted in order to help control the spread of the virus.

Signature _____Date _____