**COVID-19 SCREENING**

Please complete before your appointment.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | NOT SURE |
| Have you or anyone in your immediate household tested positive for COVID-19 in the past 14 days? |  |  |  |
| Are you or anyone in your immediate household awaiting results of a COVID-19 test? |  |  |  |
| Are you currently, or anyone in your immediate household, quarantining because of a positive test? |  |  |  |
| In the past 14 days have you had: chills, fever, shortness of breath, sneezing or coughing? |  |  |  |
| In the past 14 days have you traveled internationally? |  |  |  |

**\*If you have answered “YES”or “NOT SURE” to any of the above questions, we kindly ask that you reschedule your appointment.**