AMANDA SEAY, LLC

PATIENT SCREENING FORM

PATIENT NAME:

	PRE-APPOINTMENT	IN-OFFICE
	DATE:	DATE:
Do you have fever or have you felt hot or feverish recently (14-21 days)?	◯ YES ◯ NO	◯ YES ◯ NO
Are you having shortness of breath or other difficulties breathing?	◯ YES ◯ NO	◯ YES ◯ NO
Do you have a cough?	◯ YES ◯ NO	◯ YES ◯ NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	◯ YES ◯ NO	◯ YES ◯ NO
Have you experienced recent loss of taste of smell?	◯ YES ◯ NO	◯ YES ◯ NO
Are you in contact with any confirmed COVID-19 positive patients?	◯ YES ◯ NO	◯ YES ◯ NO
Have you travelled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	◯ YES ◯ NO	◯ YES ◯ NO
Although exposure is unlikely, do you accept the risk and consent to treatment?	◯ YES ◯ NO	◯ YES ◯ NO