

Name: \_\_\_\_\_

### COVID-19 Pre-Screening Questionnaire

To the best of your knowledge, have you or **anyone you have been in close contact** with in the last **2 weeks**:

1. Tested positive for COVID-19: Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have shown any symptoms of COVID: Yes \_\_\_\_\_ No \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for taking the time to fill out this questionnaire, which pre-screens anyone coming in our door for possible illness. We continue to keep our standards to the highest level with safety to our staff and patients as we move forward during these times.

Sincerely,

Dr. Shane Vaughn, Dr. Amiee Vaughn, and Amy Dechert RDA

