PATIENT PRE-SCREENING QUESTIONNAIRE

Please reach out to our office to reschedule your appointment if you answer **YES** to any of the following questions:

Do **YOU OR ANY MEMBER OF YOUR HOUSEHOLD** have any of the following new or worsening symptoms?		**YES**	**NO**
Do you or any member of your household have a fever and/or chills			
Do you or any member of your household have shortness of breath or other difficulties breathing?			
Do you or any member of your household currently have a new onset of cough or worsening chronic cough?			
Do you or any member of your household have decrease or loss of taste or smell?			
Do you or any member of your household have **two or more of:** • Runny nose/nasal congestion • Headache • Extreme fatigue • Sore throat • Muscle aches/joint pain • Gastrointestinal symptoms (i.e. vomiting or diarrhea)			
Have you or any member of your household tested positive for COVID -19 on PCR, rapid molecular, or rapid antigen test in the past 10 days?			
IF YES,	Have you been symptom free for 24 hours?		
	Have you isolated for a minimum of 10 days/and or have been medically cleared?		
Have you or any member of your household been in close contact with anyone that has been confirmed COVID-19 positive on PCR, rapid molecular, or rapid antigen test in the past 10 days?			