NAKATSUI
DERMASURGERY

COVID-19 Patient Screening Questionnaire

To help us provide care to our patients in the midst of the COVID-19 pandemic, we are asking all patients to provide the following information prior to making an office appointment. It is essential that this information is accurate and complete. We respect your privacy and this information will be protected. Thank you for your cooperation, Nakatsui DermaSurgery Centre.

Name_____

Date_____

Date of Birth _____

Email _____ Telephone _____

1. At any time in the past month, have you or any close contact experienced any of the following:

	You	Close Contact
Confirmed coronavirus infection	☐No ☐Yes	☐No ☐Yes
Fever	☐No ☐Yes	☐No ☐Yes
Cough	☐No ☐Yes	☐No ☐Yes
Shortness of breath	☐No ☐Yes	☐No ☐Yes
Diarrhea	☐No ☐Yes	☐No ☐Yes
Loss of smell or taste	☐No ☐Yes	☐No ☐Yes
Blisters, bumps or discoloration of the toes	☐No ☐Yes	☐No ☐Yes
Other Flu-like symptoms, including muscle aches	☐No ☐Yes	☐No ☐Yes
Conjunctivitis (pink eye)	☐No ☐Yes	☐No ☐Yes

If you answered yes, please give further explanation: _____

_____

2. Have you and your close contacts been practicing social distancing for the past 30 days?

You	Close Contact
☐No ☐Yes	☐No ☐Yes

3. Have you been in contact with anyone who has COVID-19 or who has ben exposed to anyone else with COVID-19? ☐No ☐Yes

3. Please list all travel in the past 30 days: _____

_____

Comments: _____

I pledge that the above statements are true, accurate, and complete

Patient Signature: _____

Date: ____/_____/_____