NAKATSUI
DERMASURGERY

PLEASE FILL IN THE SAME DAY AS YOUR APPOINTMENT & FAX TO : 780-482-7097 OR EMAIL : info@nakatsuiderm.com

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 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 within the last three weeks--------	☐No ☐Yes	---------☐No ☐Yes
Fever ----------	☐No ☐Yes	---------☐No ☐Yes
New cough or worsening of chronic cough----------	☐No ☐Yes	---------☐No ☐Yes
New shortness of breath or worsening of shortness of breath-------	☐No ☐Yes	---------☐No ☐Yes
Diarrhea or vomiting----------	☐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
New onset of rash----------	☐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 within the last two weeks? ☐No ☐Yes

4. Please list all travel in the past 30 days out of Alberta: _____

_____

Comments: _____

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

Patient Signature: _____

Date: ____/_____/_____