Henry Vision Center COVID-19 Patient Questionnaire

Patient Name: _____ Date: _____

Appointment Time: _____ Temperature: _____

IF A TEMPERATURE IS TAKEN AND READS 38.0 (100.0F) OR HIGHER PATIENT MUST RESCHEDULE

Due to COVID-19 the following questions must be answered, if any of the questions are answered YES you may be required to reschedule your appointment at a later date and time. We at Henry Vision Center appreciate your cooperation in keeping us all safe and healthy.

Have you had any of the following symptoms in the last 2 weeks?

Fever _____ Nausea _____ Runny Nose _____ Vomiting _____

Cough _____ Diarrhea _____ Shortness of Breath _____

Have you been near anyone with these symptoms in the last 2 weeks? _____

Have you tested positive for COVID-19? _____ If so When? _____

Have you been around anyone who tested positive for COVID-19? _____

If so when? _____ When did they test positive? _____

Have you visited any healthcare facilities such as nursing homes, convalescent centers, hospitals, or visited a prison? _____ If so when? _____

Are you a Health Care Worker who has taken care of any COVID-19 patients? _____

If so have you been tested? _____ If so When? _____

Effective 04/30/2020