SOUND ADVICE

COVID-19 PRE-VISIT SURVEY

PERSONAL INFORMATION

Name _____
Title First MI Last

Date of Birth _____
MM/DD/YYYY

ALTERNATIVE CONTACT INFORMATION

Name _____
Title First MI Last

☐ Is primary contact

COVID-19 PRE-VISIT SURVEY

Have you been vaccinated against COVID-19?

☐ Yes ☐ No If so, which vaccine(s)? _____

Date of first vaccination: _____

Date of second vaccination, if applicable: _____

Date of latest booster, if applicable: _____

Please indicate if you are experiencing any of the following symptoms

☐ Yes ☐ No Do you have a fever now, or have you had one within the last 14 days?

☐ Yes ☐ No Do you have a cough?

☐ Yes ☐ No Have you been in contact with a confirmed COVID-19 patient in the last 14 days?

☐ Yes ☐ No Are you experiencing shortness of breath or difficulty breathing?

☐ Yes ☐ No Are you experiencing flu-like symptoms such as gastrointestinal upset, headache or fatigue?

☐ Yes ☐ No Have you experienced a recent loss of taste or smell?

By signing below, you are attesting that everything you stated above is truthful and accurate to the best of your knowledge.

PATIENT SIGNATURE

Patient signature or legal custodian _____
Please sign here

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