EyeCare Associates

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MICHAEL C. MORRIS, O.D. **THEAR BUN, O.D**

Covid-19 Screening Form

Patient Name: _____

DOB: _____

Today's Date: _____/_____/_____

Please circle YES or NO to the following questions:

	Yes	No
1. Have you traveled domestically or internationally in the last 14 days?	☐	☐
2. Have you been in close contact with anyone who has traveled domestically or internationally in the last 14 days?	☐	☐
3. Have you attended any events or gatherings with more than 25 people?	☐	☐
4. Have you been in close contact with a person known to have Covid-19? a. If yes, how long ago? _____ Were you tested? _____ How long ago?_____	☐	☐
5. Are you experiencing any cold/flu like symptoms such as a cough, sore throat, runny nose or/and shortness of breath?	☐	☐

If you have answered YES to any of the above question, we may have to reschedule your appointment.