Today's Date: ____________

Patient's Name: ____

1. Within the last 14 days, have you been sick with a fever, chills or fatigue (flu-like symptoms)? Have a dry cough? Or experiencing a shortness of breath? Have you experienced recent loss of taste or smell? If yes, please explain and list your symptoms:
    a. YES __________________ b. NO _____________________

2. Within the last 14 days, have you traveled out of Michigan or to regions affected by COVID -19? If yes, where to?
    a. YES __________________ b. NO _____________________

3. Have you been in close proximity to any people who are known to have tested positive to COVID-19? If yes, who and where?
    a. YES __________________ b. NO _____________________

4. Have you knowingly been in close contact with any persons who have experienced COVID-19 symptoms?
    a. YES __________________ b. NO _____________________

5. Have you recently participated in any gatherings, meetings, or had close contact with people who do not reside permanently with you in your household?
    a. YES __________________ b. NO ______________________

Patients Signature: ____

*_Any response to yes please call the office prior to your appointment_