WEST END
PLASTIC SURGERY

COVID-19 SCREENING QUESTIONAIRE

Please answer the following by circling YES or NO:

1. Have you been within 6 feet of a person with a lab-confirmed case of COVID-19, or had direct contact with their mucus or saliva, in the past 14 days? YES / NO

2. In the last 48 hours, have you had any of the following symptoms?

Fever of 100.4 F (38 C) or above	YES / NO
New trouble breathing, shortness of breath or severe wheezing	YES / NO
New chills, shivering, or sweating	YES / NO
New muscle aches	YES / NO
Sore throat	YES / NO
Diarrhea	YES / NO
New loss of smell or taste, or a change in taste	YES / NO

3. Have you been tested for COVID-19 ?
If so, date_____ result_____ YES / NO

4. Have you recently traveled to or from an area that is considered high-risk for COVID-19 in the last 2 weeks? YES / NO

5. Have you been in contact with someone who has traveled to these countries? YES / NO

6. Have you been told by a public health official that you may have been exposed to coronavirus (COVID-19)? YES / NO

7. Have you followed social distancing and routine hand hygiene practices over the past 4 weeks? YES / NO

8. Are you employed in a grocery store, hospital, medically related environment, or other “essential service” environment? YES / NO

9. If I test positive for COVID-19 during the next two weeks I will notify West End Plastic Surgery immediately YES / NO

I attest that the above answers are true. _____ _____
signature date

Printed Name_____