COVID-19 Screening Questionnaire

Patient Name:____Date:___________

In response to the Coronavirus (COVID-19) outbreak Novi Ophthalmology, PC will be following the guidance of the Centers for Disease Control and Prevention (CDC). To protect everyone, including staff, we are asking all visitors to complete the following questionnaire. Please visit https://www.cdc.gov for further information.

Please review the following self-screening criteria:

	Yes	No
Have you or anyone in your household had any of the following symptoms in the last 21 days: • sore throat, • cough, chills, • body aches for unknown reasons, • shortness of breath for unknown reasons, • loss of smell, loss of taste, • fever at or greater than 100 degrees Fahrenheit?	☐	☐
Have you or anyone in your household been tested for COVID-19?	☐	☐
Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?	☐	☐
Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?	☐	☐
To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?	☐	☐

If answered YES to any of the above questions please leave the waiting room and call 248-697-2822 from outside the office for further direction.