*David Stephens, MD Center for Plastic Surgery Medical Aesthetics & Advanced Skin Care*

**COVID-19 Patient Screening Form**

Name: _____ DOB: _____

**In the last 14 days, have you had any of the following symptoms:**

| Y | N | |
|---|---|---|
| ☐ | ☐ | Fever |
| ☐ | ☐ | Shortness of breath or having trouble breathing |
| ☐ | ☐ | Dry cough |
| ☐ | ☐ | Lost or had a reduction in your sense of smell or taste |
| ☐ | ☐ | Sore throat |
| ☐ | ☐ | Diarrhea, nausea, or vomiting |
| ☐ | ☐ | Chills |
| ☐ | ☐ | Muscle aches, body aches, or headaches |
| ☐ | ☐ | Fatigue |

**In the last 14 days:**

☐ ☐ Have you been in contact with someone with any of the above symptoms?

If yes, please enter the date of last contact: _____

☐ ☐ Have you been in contact with someone who has tested positive for Covid-19?

If yes, please enter the date of last contact: _____

☐ ☐ Have you traveled outside Washington State? If yes, where: _____

☐ ☐ Have you been tested for COVID-19?

**If yes, what was the result of the testing?**

☐ Negative ☐ Unsure ☐ Positive

Patient Signature: _____ Today's Date: _____

**OFFICE USE ONLY**

Pt. Temperature: _____ Date/Time: _____ Staff Initials: _____