4/20/2020

Zusman Eye Care Center Screening Questionnaire
Please Fill Out Completely and Bring to Your Appointment

Date: _____ **Time**: _____

First Name: _____**MI**: _____ **Last Name:** _____

Reason for Visit: Patient / Visitor / Employee / Vendor

If visiting with patient, Patient Name: _____

"Welcome to Zusman Eye Care Center. To help protect the safety of our patients and staff, we are asking all patients and approved visitors to wear a mask."

SECTION 1	**Actual Temperature:_____**	
Temperature: do you have a temperature over 100?	No	Yes
SECTION 2 - Do you have any of the following symptoms:		
Recent/New Onset Coughing (not related to allergy or COPD)	No	Yes
Nasal Congestion (not related to allergies or sinus infections)	No	Yes
Recent/New Onset Sore Throat	No	Yes
Recent/New Onset Shortness of Breath (not related to chronic disease)	No	Yes
Recent/New Onset Diarrhea	No	Yes
Recent/New Onset Nausea/Vomiting	No	Yes
Recent/New Onset Fatigue/Malaise	No	Yes
Recent/New Onset of Loss of Taste/Smell	No	Yes
SECTION 3 - COVID-19 Exposure		
Are you living with someone that is quarantined or furloughed?	No	Yes
Have you been in contact with an individual positive for COVID-19?	No	Yes
Have you been in contact with a Person Under Investigation (PUI) COVID-19?	No	Yes
Are you considered a Person Under Investigation (PUI) COVID-19?	No	Yes
SECTION 4 - Personal COVID-19 Exposure		
Have you tested positive for COVID-19?	No	Yes