Patient Screening Form

Patient Name (PRINT): _____ **Date of Birth**: _____

Please read the questions and select answer. If you cannot affirm "NO" to all questions, your appointment will be rescheduled or postponed.

	Pre-appointment		**In-office**	
	Date:		Date:	
Do you/they have a fever, felt hot or feverish recently (14-21 days)?	☐YES	☐NO	☐YES	☐NO
Are you/they having shortness of breath or other difficulties breathing?	☐YES	☐NO	☐YES	☐NO
Do you/they have a cough?	☐YES	☐NO	☐YES	☐NO
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐YES	☐NO	☐YES	☐NO
Have you/they experienced recent loss of taste or smell?	☐YES	☐NO	☐YES	☐NO
Are you/they in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should postpone elective treatment.	☐YES	☐NO	☐YES	☐NO
Have you/they traveled in the past 30 days to any foreign countries or within the United States?	☐YES	☐NO	☐YES	☐NO

I answered the health questionnaire above honestly and to the best of my knowledge. I understand that Canyon Eyecare, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definite way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Canyon Eyecare or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positive or presumed positive with the COVID-19 virus. There are certain inherent risks associated with an eye exam during the pandemic, and I assume full responsibility for any personal illness that may result.

Patient/Guardian Signature:_____ **Date**:_____