COVID-19 Screening

In an effort to help prevent the spread of COVID 19, and to protect both our patients and staff from the pandemic we now find ourselves in, we ask that you take a minute to complete this questionnaire. Please complete this just prior to the day of your appointment, and bring it with you to your appointment. If you have checked any of the questions below please call our office immediately. Lastly, for everyone's safety be sure to wear your mask when you arrive for your appointment.

Please check all that apply

___ I have been in contact with someone who has COVID-19.

___ I have tested positive for COVID-19.

___ In the last month I have traveled to or from areas heavily affected by COVID-19.

___ I have experienced cold or flu-like symptoms in the last 4 weeks.

___ I have experienced a fever or chills in the last 4 weeks.

___ I have experienced shortness of breath in the last 4 weeks.

___ I have experienced body aches or fatigue in the last 4 weeks.

___ I have experienced either a dry or a wet cough in the last 4 weeks.

___ I have experienced congestion in my sinuses, and or post nasal drainage in the 4 weeks.

___ I have experienced gastrointestinal upset in the last 4 weeks.

___ I have experienced a loss or decrease in your senses of taste or smell in the last 4 weeks.

___ Somebody at my home has had some of the symptoms mentioned above.

I agree to notify Dr. Dailley's office if within 14 days of going to his office if I develop any of the above symptoms or test positive for COVID-19. I also understand Dr. Dailley's office has a legal and ethical obligation to inform me if a staff member I have had contact with tests positive for COVID-19.

Patient name: _____ Date: _____