INFECTIOUS DISEASE HEALTH SCREENING

Patient Legal Name:

Last Name: First Name: Middle Initial:

Please complete the following questions upon arrival for pre-operative appointment:

1. Have you received the flu vaccination (Flu Shot / Flu Nasal Mist) for the current flu season? ☐ Yes ☐ No
2. Do you currently have a fever (100.4 degrees F/38.0 degrees C)? ☐ Yes ☐ No
3. Do you currently have any of the following symptoms?
   - Headache ☐ Yes ☐ No
   - Weakness ☐ Yes ☐ No
   - Muscle Pain (pertaining to flu-like symptoms) ☐ Yes ☐ No
   - Vomiting ☐ Yes ☐ No
   - Diarrhea ☐ Yes ☐ No
   - Abdominal (stomach) Pain ☐ Yes ☐ No
   - Hemorrhage (bleeding or bruising) ☐ Yes ☐ No
4. Have you travelled outside of the U.S in the past 2 months? ☐ Yes ☐ No
   If Yes, when and where:
5. To your knowledge, have you had contact with anyone that has been exposed to or diagnosed with an infectious disease in the past 2 months? (Ebola, Coronavirus, Flu etc.) ☐ Yes ☐ No
   If Yes, when and where:
6. Have you been COVID tested? ☐ Yes ☐ No
   Result:
7. Have you received the COVID vaccine? ☐ Yes ☐ No

Completed By:		
Patient Signature:	Date:	Time:
Reviewed By:		
R.N. Signature:	Date:	Time:

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