All Eyes On You
OPTOMETRY INC

# COVID-19 PATIENT QUESTIONNAIRE

The safety of our patients and all employees will always be our top priority. For this reason, only those people who have a direct need to be in the office – for an exam, vision therapy, or other necessary vision-related function – will be permitted inside the building. To prevent the spread of COVID-19 and reduce the potential risk of exposure to our staff and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time and cooperation.

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Patient Name (please print)

1. Have you returned from any countries outside the United States within the last 14 days? Yes No

2. Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? Yes No

3. Have you been in close contact with anyone who has traveled outside the United States within the last 14 days? Yes No

4. Have you experienced any cold or flu-like symptoms in the last 14 days (including fever, cough, sore throat, respiratory illness, difficulty breathing)? Yes No

If the answer is “Yes” to any of these questions, it is imperative that you reschedule your appointment. We assure you that your appointment will be rescheduled to the very earliest date that coincides with the passage of the necessary 14-day exclusionary period.

_____ _____

Signature Date