WILLIAM S. GOLDSTEIN, MD
LASER EYE CARE CENTER

COVID-19 SCREENING CHECKLIST

PATIENT NAME: _____ DATE: _____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? OR WITHIN THE LAST 14 DAYS?

___ yes ___ no * FEVER of 100.4 or HIGHER or CHILLS

____ yes ___ no * NEW DIFFICULTY BREATHING or SHORTNESS OF BREATH

___ yes ___ no * NEW COUGH

____ yes ___ no * SORE THROAT

____ yes ___ no * NEW MUSCLE ACHES

____ yes ___ no * NEW LOSS OF TASTE OR SMELL

____ yes ___ no * HAVE YOU HAD CONTACT WITH ANYONE WHO HAS ANY THESE SYMPTOMS WITHIN THE LAST 14 DAYS?

____ yes ___ no * HAVE YOU HAD CONTACT WITH ANYONE WITH CONFIRMED COVID-19 WITHIN THE LAST 21 DAYS?

Recorded Temperature: _____ Time: _____

HAS THIS INDIVIDUAL USED AN ALCOHOL-BASED HAND SANITIZER UPON ENTRY?

_____ yes _____ no

OFFICE STAFF INITIALS:_____