AUDIOLOGY
EAR CARE

COVID-19 SCREENING QUESTIONNAIRE

Please answer all questions upon check-in for your appointment and prior to seeing the audiologist. If completed at home, please complete on the day of your appointment. if you answer "YES" to any questions, please contact us to determine whether you should keep your appointment.

Name: _____ Date: _____

Have you or anyone in your household had any of the following symptoms in the last 21 days. If yes, please indicate which symptom(s) and when. ☐ YES ☐ NO

- Sore throat
- Cough
- Chills
- Body aches for unknown reasons
- Shortness of breath for unknown reasons
- Loss of smell
- Loss of taste
- Fever of 100 degree F or greater

Have you or anyone in your household tested positive for COVID-19? ☐ YES ☐ NO

Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? ☐ YES ☐ NO

Have you or anyone in your household traveled within the U.S. in the past 21 days? ☐ YES ☐ NO

Have you or anyone in your household traveled on a cruise ship in the last 21 days? ☐ YES ☐ NO

Are you or anyone in your household a health care provider or emergency responder? ☐ YES ☐ NO

Have you or anyone in your household cared for an individual who is in quarantine, is a presumptive positive, or has tested positive for COVID-19? ☐ YES ☐ NO

Do you have reason to believe you or anyone in your household has been exposed to or acquired COVID-19? ☐ YES ☐ NO

To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? ☐ YES ☐ NO

Please be sure to wear a mask during your appointment. If you have any questions, please ask our staff.