Eye Clinic of Edmonds

Patient Screening Form

Name:

Date:

	Pre-Appointment		In Office	
Any fever recently (last 14-21 days)?	□ Yes	□ No	□ Yes	□ No
Any SOB (shortness of breath)?	□ Yes	□ No	□ Yes	□ No
Any cough?	□ Yes	□ No	□ Yes	□ No
Any flu-like symptoms, GI upset, HA, fatigue?	□ Yes	□ No	□ Yes	□ No
Any loss of taste or smell?	□ Yes	□ No	□ Yes	□ No
Any contact with known COVID + patients?	□ Yes	□ No	□ Yes	□ No
Over 60 years old?	□ Yes	□ No	□ Yes	□ No
Any known DM/heart/lung/kidney disease?	□ Yes	□ No	□ Yes	□ No
Any auto-immune disorders?	□ Yes	□ No	□ Yes	□ No
Any foreign travel in past 14 days?	□ Yes	□ No	□ Yes	□ No

Any positive responses require physician discussion prior to elective treatments.