NAME:_____DOB: _____ DATE:_____ PHONE #:_____

Please complete form and drop off **no more than 24 hours prior** to your appointment with Dr. Rider. Drop form in marked box at our front door and return to your car or if early come back for your scheduled appointment.

PLEASE ANSWER EVERY QUESTION TRUTHFULLY	YES/NO	DETAILS
Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, what were the symptoms, when did the symptoms start, when did the symptoms stop		
Have you or a member of your household been tested for COVID-19? (If yes, give date of test, results of the test, whether the person is currently in quarantine and the status of the person's symptoms.)		
Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers? (If yes, why was the recommendation made, when was the recommendation made, did testing occur, when did any symptoms start and stop and the current health status of the person who was advised.)		
Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers? (If yes, why was the recommendation made, when was the recommendation made, did testing occur, when did any symptoms start and stop and the current health status of the person who was advised		
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? (If yes, give the facility name, location, reason for visit/treatment and dates.)		
Have you or a member of your household traveled outside the U.S. in the past 30 days? (If yes, provide the city, country and dates.)		
Have you or a member of your household traveled elsewhere in the U.S. in the past 21 days? (If yes, provide the city, state and dates.)		
Have you or a member of your household traveled on a cruise ship in the last 21 days? (If yes, provide the name of the ship, ports of call and dates.)		
Are you or a member of your household healthcare providers or emergency responders? (If yes, what type of work the person does and whether the person is still working. For example, ICU nurse actively working versus a furloughed firefighter.)		
Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? (If yes, give the status of the person cared for, when the care occurred, what the care was.)		
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, give information about the believed source of the potential exposure and any signs that the person acquired the virus.)		
To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? (If yes, give information about when the contact occurred, what the contact was, how long the people were in contact and when the diagnosis occurred.)		