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**COVID-19 Prescreening Questionnaire**

**Patient Name:**

**Date of Birth:**

**What is the date of your upcoming appointment?**

**Have you or anyone you have been in contact with recently traveled outside of Washington in the last 14 days**?

O Yes O No

**Do you, or anyone you have been in contact with recently, have any of the following symptoms - cough, fever, sore throat, or any difficulty breathing?**

O Yes O No

**Have you had any contact with anyone known or suspected to have COVID-19, including any contacts at work?**

O Yes O No

**Do you own a protective face mask?**

O Yes O No

**Yes - Please remember to wear your mask when you come to your appointment.**