M.A.R.C.
MEDICAL AESTHETICS & REJUVENATION CENTER

COVID-19 Screening Form

Purpose: If you have been exposed to a communicable disease, you may spread the disease to staff and/or other patients. Therefore, prior to each appointment, we will be asking the following questions to reduce the chance of transmission.

Do you or anyone you have recently been in contact with have any of the following symptoms (check yes or no):

Fever (defined as above 100.4 F)? Yes _____ No _____

Chills? Yes _____ No _____

Cough? Yes _____ No _____

Sore Throat? Yes _____ No _____

Shortness of Breath and /or trouble breathing? Yes _____ No _____

Persistent pain, pressure or tightness in the chest? Yes _____ No _____

New loss of taste or smell? Yes _____ No _____

Traveled outside of our local area or outside of the US within 14 days? Yes _____ No _____

If yes provide approximate dates of illness:

_____/_____/_____ through _____/_____/_____

I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's appointment to a later date.

Patient Name: _____

Patient Signature: _____

Date: _____