**WOODLANDS WELLNESS & COSMETIC CENTER**

**COVID-19 IN-PERSON APPOINTMENT PRE-SCREENING FORM**

**Patient Name: DOB:**

**Appointment Date/Time: Temperature:**

**PRESCREENING QUESTIONNAIRE**

**1. Are you experiencing any of the following:**

* Fever over 100.4
* New or Persistent cough
* Shortness of breath
* Runny nose
* Sore throat
* Fatigue, aches and pains
* Severe GI distress or diarrhea
* Loss of sense of smell

**2. Have you been in contact with anyone in the last 14 days who is experiencing these symptoms?**

* Yes
* No

**3.** **Have you been in contact with anyone who has since tested positive for Covid-19?**

* Yes
* No

*By signing below, I confirm that all my answers are honest and correct.*

**Signature**: **Witness/MA**: