Women's Health Partners, LLC

Diplomates of the American Board of Obstetrics & Gynecology
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COVID19 Patient Questionnaire

The safety of our patients, visitors and staff remain our overriding priority. To prevent the spread of COVID-19 and reduce the potential risk of exposure to our patients and staff, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building.

Thank you for your time and understanding.

1. To your knowledge, have you had close contact with or cared for someone who was checked as a suspected case of, or was diagnosed with, COVID-19 virus within the last 14 days?

   ○ **YES** ○ **NO**

2. Have you or anyone in your household had any of the following symptoms in the last 14 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?

   ○ **YES** ○ **NO**

3. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19, within the last 14 days?

   ○ **YES** ○ **NO**

If you answered "YES" to any of the above, you may be asked to refrain from entering our office or leave the facility. You should self-isolate yourself and call your primary care physician for further instructions.

You will need to reschedule your appointment until all the above questions can be answered by "NO".

_____ _____ _____

Patient Signature Date Account #

_____

Patient Name (Print)

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