Covid-19 FEES Health Screening Form

Name: ____ **Date of FEES:** ___________________

Date of Birth: _____________________ **Endoscopist:** ______________________________

Ordering Physician: __________________________________

Do you currently have, or have you in the last week had, any of the following symptoms?

- ☐ Fever
- ☐ Cough
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ New loss of taste or smell
- ☐ Diarrhea

Does any member of your household have any of the above symptoms? YES NO

Has anyone in your household tested positive for COVID-19? YES NO

Has anyone in your home recently been tested for COVID-19 and is awaiting the results?
YES NO

In the last 14 days, has anyone in your family been asked to self-isolate or quarantine?
YES NO

In the last 14 days, have you had close contact with an individual diagnosed with COVID-19?
YES NO

*If the answer to any of the above questions is yes, the appointment will have to be rescheduled until you have tested negative on a Covid-19 test.

I verify that I have answered the above questions truthfully and to the best of my knowledge.

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Signature

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