Wellness Form

Have you been tested for COVID 19 and pending results?

Yes ◌ No ◌ If yes, When ___________ Results: NEGATIVE POSTIVE

Have you been recently tested for COVID 19 and pending retest or have been retested and results persisted positive?

Yes ◌ No ◌ If yes, When ___________

Has anyone in your household been tested for COVID 19?

Yes ◌ No ◌ If yes, When ___________ Results: NEGATIVE POSTIVE

In the past 20 days, have you had any of the following symptoms: fever, chills, cough, sore throat, loss of appetite, abdominal pain?

Yes ◌ No ◌

In the past 20 days, has anyone in your household had any of the following symptoms: fever, chills, cough, sore throat, loss of appetite, abdominal pain?

Yes ◌ No ◌

In the past 20 days, has anyone you have come into contact with, outside of household members, had (for example co-workers) any of the following symptoms: fever, chills, cough, sore throat, loss of appetite, abdominal pain?

If anyone I encounter, inside and/or outside of household members, (for example co-workers) become positive with COVID 19 I agree to call and notify the office of ***Mario A. Caballero, OD & Staff***

PRINT First Name: ________________________ Last Name: ________________________

SIGNATURE: ______________________________ Email: ______________________________

DOB: ______________ Date: ______________