VEINMEDIC

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Minimally Invasive Treatment
of **Venous Insufficiency** and **Varicose Veins**
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COVID - 19 Screening Form

Patient Name: _____ D.O.B: _____ Date: _____

Please circle **YES** or **NO** to the following questions:

1. Have you or traveled outside of the USA in the last 14 days ☐ YES ☐ NO

2. Have you traveled within the USA in the last 14 days? ☐ YES ☐ NO

3. Have you been on a cruise ship in the last 14 days? ☐ YES ☐ NO

4. Have you and/or the patient been in close contact with anyone who has traveled domestically or internationally in the last 14 days ☐ YES ☐ NO

5. Have you attended any events or gatherings with more than 100 people ☐ YES ☐ NO

6. Have you been in close contact with a person known to have the 2019 Novel Coronavirus ☐ YES ☐ NO

7. Have you and/or the patient been asked to self-quarantine? ☐ YES ☐ NO

8. Do you currently have fever or lower respiratory symptoms such as a cough or shortness of breath? ☐ YES ☐ NO

9. Do you have a new onset of cold symtoms such as a cough and runny nose? ☐ YES ☐ NO

10. Have you had a COVID-19 / Antibody test? ☐YES ☐NO