YOUR TWO EYES OPTOMETRY: COVID 19 SCREENING

For the safety and protection of you, your household, our patients, and our team of providers we kindly ask that you fill out and sign the following form and follow the protocol explained below. If we have concerns about your health this form will determine the safest means possible to assist you with your eye care needs.

We will take your temperature prior to your appointment. You will be asked to wait outside until your appointment time. Please provide a contact number if you wish to wait in your car and we will call you when it is time for your exam.

You will not be allowed to enter without a face mask that covers nose and mouth well. If you have an N95 mask, please wear it to your appointment. If your mask is deemed insufficient you will be provided with a disposable surgical mask to wear during your appointment. If you have an additional person with you, please ask them to remain outside. If they are needed for the appointment they must follow this protocol as well.

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1. Do you or a member of your household have any health conditions that heighten your risk of contracting an infection (e.g., asthma, immune compromised)? ☐YES ☐NO
   If yes, please explain: _____

2. Are you or a member of your household an essential worker that works directly with the public (e.g., healthcare, grocery stores, restaurants)? ☐YES ☐NO
   If yes, please explain: _____

3. In the last 14 days have you been in close proximity to people outside of your household or allowed social bubble for activites other than your typical work or errands (including but not limited to: airplane travel, subway, public transportation, haircut or nail salon appointments, public event, public demonstration or social gathering, emergency room care, inpatient hospitalization, outpatient procedure or dental care)?
   ☐YES ☐NO If yes, what activity and when: _____

4. Have you or a member of your household had contact with another person with confirmed or suspected COVID 19 in the past 14 days? ☐YES ☐NO

5. Have you tested positive for COVID 19 in the past 14 days? ☐YES ☐NO

6. In the last 14 days, have you experienced (check the box if YES):

☐ cough	☐ sore throat
☐ shortness of breath	☐ new loss of taste or smell
☐ difficulty breathing	☐ nausea
☐ fever	☐ vomiting
☐ chills	☐ diarrhea
☐ muscle pain	☐ pink eye/conjuntivitis
☐ upper respiratory infection	☐ red/itchy/watery eyes

PATIENT NAME _____ PHONE _____

SIGNATURE _____ DATE _____