COVID-19 SCREENING

SHEEHY
ANKLE & FOOT CENTER
PAUL L SHEEHY, JR., DPM, Medical Director

Patient Name: ______________________________ Date: ____________________

PLEASE LET US KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING:

NO	YES	
		Fever greater than 100F
		Cough/Shortness of Breath
		Pneumonia/flu – recent
		Have you traveled out of the country in the last 14 days to China, Japan, Italy, Iran, or S. Korea
		Have you had contact with anyone who has lab confirmed Coronavirus within 14 days of symptom onset?
		Have you been on a cruise in the last 14 days?
		Have you been vaccinated?

1st dose: ______________________________

2nd dose: ______________________________

Booster: ______________________________

Patient Signature: ______________________________