Geoffrey E. Leber, MD
AESTHETIC PLASTIC SURGEON
SCOTTSDALE & BOSTON

COVID-19 Screening Questionnaire

1. Have you or anyone in your household travelled internationally within the last 30 days?

   a. Yes _____ No _____

   b. If yes, where? _____

2. Have you had close contact with a suspected or laboratory-confirmed COVID-19 patient in the past 2 weeks?

   a. Yes _____ No _____

3. If you answered 'yes' to either Questions 1 or 2, have you had a negative COVID-19 test in the past 2 weeks? If 'yes', please list date of test.

   a. Yes _____No _____

4. In the last **72 HOURS** have you had:

a. Temperature of 100.4 degrees or higher; repeated shaking chills	a. YES_____	NO_____
b. Cough	b YES_____	NO_____
c. Shortness of breath	c. YES_____	NO_____
d. Sore throat	d. YES_____	NO_____
e. Congestion/runny nose	e. YES_____	NO_____
f. Headache	f. YES_____	NO_____
g. Nausea/Vomiting/Diarrhea	g. YES_____	NO_____
h. Muscle or body aches; Fatigue	h. YES_____	NO_____
i. New onset loss of taste or smell	i. YES_____	NO_____

5. The following patients will be canceled/rescheduled if they have:

- Flu-like symptoms
- Temperature of 100.4 degrees or greater
- Contact with a suspected or confirmed COVID-19 patient (unless testing negative or COVID-19 in past 2 weeks)
- Quarantine order issued
- Visited a Level 2 or 3 Travel Health Notice country in the past 2 weeks
- Returned from a cruise in the past 2 weeks

Print Name: _____

Signature: _____ Date: _____

Dr. Leber Employee: _____ Date: _____