Brevard Ear, Nose & Throat Center

Dear Patient/Visitor:
We appreciate your participation in completing and answering the screening questions to determine any risk factor for exposure to the COVID-19 virus. These screening questions will need to be completed at each patient visit until the CDC states that this virus is no longer a threat. Our main goal is to protect the health of our patients, visitor, and staff. We will take every measure to ensure everyone's safety.

Patient Name:_____ DOB:_____
Account#_____

1. Have you been tested for COVID-19 by nasal swab and/or blood test in the past 14 days? Yes or No
   If YES, have you received the results? YES or NO Results: Positive or Negative

2. Have you traveled outside the state in the last 30 days? YES or NO
   If yes, where:_____

3. Do you have or have you had any of the following symptoms in the last 14 days?
   Cough - Yes or No
   Shortness of breath or difficulty breathing - Yes or No
   Sore throat - Yes or No
   Loss of taste or smell - Yes or No
   Fever greater than 100 - Yes or No
   Fatigue - Yes or No
   Fever or chills - Yes or No
   Muscle or body aches - Yes or No
   Headache - Yes or No
   Congestion or runny nose - Yes or No
   Nausea or vomiting - Yes or No
   Diarrhea - Yes or No

4. To your knowledge, have you been in contact with any individual diagnosed with COVD-19 in the past 14 days? Yes or No

Important information:
For the safety of patients and staff, we are requiring patients with in-office appointments to wear a face mask. This is the most recent guidelines per the CDC in order to help lower the risk of contracting this virus.

_____ _____
Patient/Visitor Signature Date

_____ _____
Employee Verification – Print Name & Signature Date