Adirondack Eye Physicians & Surgeons P.C./ Bay Optical, Inc

COVID-19 Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

	YES	NO
• Do you have a fever?	◯	◯
• Do you have a cough?	◯	◯
• Do you have any shortness of breath?	◯	◯
• Have you tested positive for COVID-19?	◯	◯
• Have you been in near anyone who has tested positive for COVID-19?	◯	◯
• Have you traveled out of the area recently?	◯	◯

If you answered yes to any of the above questions, we ask that you reschedule your appointment.

_____ _____

Signature of Patient Date