CHRISTIANA
cosmetic surgery consultants

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Due to the ongoing COVID-2019 Pandemic, all patients are required to complete this form prior to being seen by the Physician's in our office. Your visit is subject to approval upon completion of this form. These rules are being enforced to keep our patients and staff as well as the rest of your loved ones safe and healthy.

Has the patient or anyone in your household have travelled **outside the United States in the past 2 weeks (14 days)** **IF YES, WHERE _____**	YES	NO
Has the patient or anyone in your household have travelled **outside of Delaware in the past 2 weeks (14 days)** **IF YES, WHERE _____**		
In the past **2 weeks (14 days)** has the patient or anyone in your household had contact with any person **suspected to have contracted COVID-19**? This includes being ***tested*** for COVID-19, & being in ***self isolation*** for COVID-19		
In the past **2 weeks (14 days)** has the patient or anyone in your household had contact with any person **confirmed to have contracted COVID-19**?		
Has the patient currently been exposed to someone **with flu-like symptoms (cough, shortness of breath or fever)**		
PLEASE <u>CIRCLE</u> IF SYMPTOMS ARE CURRENTLY BEING EXPERIENCED BY CAREGIVER, PATIENT OR BOTH		
In the last 72 hours has the Patient experienced:		
FEVER		
COUGHING		
SORE/THROAT		
DIFFICULTY BREATHING, SHORTNESS OF BREATH OR WHEEZING		
MUSCLE ACHES		
STOMACH PAINS		
VOMITING OR DIARRHEA		
PINK EYE/ RED EYES		
RASH		
FATIGUE OR FEELING UNWELL		

*****Please return this form to the front desk when completed*****

By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.

Patient/Caregiver: _____ Date:_____

Patient Signature: _____ Patient temp: _____