DR. LEE B. DANIEL

AESTHETIC PLASTIC SURGERY · THE SPA SIDE

Covid-19 Health Screening Form

Are you currently experiencing any signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat?

- ❑ Yes
- ❑ No

Have you experienced any of these symptoms within the last 14 days?

- ❑ Yes
- ❑ No

Have you been exposed to anyone experiencing COVID-19 symptoms or that has a confirmed diagnosis of COVID-19?

- ❑ Yes
- ❑ No

Have you traveled internationally within the last 14 days?

- ❑ Yes
- ❑ No

_____

Patient Signature *Date*

_____

Witness *Date*