

Welcome to Bee Cave Dermatology – To protect you, our patients and staff please answer all the questions, sign, and date. We will take your temperature and take you to your room.

Please circle Yes or No

Yes No Have you had and recovered from COVID 19?

If yes when _____

Yes No Have you been exposed or had contact with a COVID 19 patient?

If yes explain _____

Yes No Have you been to a mass gathering of more than 10 people?

If yes explain and when _____

Yes No Do you have a fever, cough, shortness of breath, sore throat?

Yes No Do you have loss of taste or smell?

Yes No Do you have diarrhea, nausea, vomiting, stomach pain?

Yes No Have you travelled outside the Austin area? If yes explain _____

Printed Name _____

Signature (or legal guardian signature if minor)

Date _____

Patient temperature (for office use only) _____