Obstetrics & Gynecology Associates

Obstetrics & Gynecology Associates takes the health and wellbeing of our community, patients, staff and providers seriously. By signing below, you are attesting to the accuracy of the medical information you provided to our staff during your health screening, you are not experiencing any of the symptoms below and you have not been exposed to or diagnosed with Covid 19 within the last 10 days.

MASKS ARE REQUIRED TO BE WORN DURING THE DURATION OF YOUR VISIT

___No	____Yes	Do you have a cough or have you had a cough within the last 10 days
___No	____Yes	Do you have a fever, body aches or chills or had them within the last 10 days
___No	____Yes	Do you have a runny nose or have you had one within the last 10 days
___No	____Yes	Do you have chest congestion or have you had congestion within the last 10 days
___No	____Yes	Do you have nasal congestion or have you had it within the last 10 days
___No	____Yes	Do you have a sore throat or have you had one within the last 10 days
___No	____Yes	Do you have a headache
___No	____Yes	Do you have diarrhea or have you had diarrhea within the last 10 days
___No	____Yes	Are you having trouble breathing or have you had trouble within the last 10 days
___No	____Yes	Do you have muscle pain or weakness or have you had it within the last 10 days
___No	____Yes	Have you lost your sense of taste or smell?
___No	____Yes	Do you have seasonal allergies and are you experiencing symptoms today
___No	____Yes	Do you have a Covid test pending
___No	____Yes	Have you tested positive for Covid within the last 14 days
__ No	____Yes	Have you had close contact with a person who has been diagnosed with Covid (continuous exposure of 15 minutes or multiple brief encounters totaling 15 +)
___No	____Yes	Have you traveled by plane within the last 10 days

If you answered yes to ANY of the questions above kindly call our office prior to your appointment for additional screening.

Print Name: _____

Date of Birth: _____

Signature: _____