Patient Name: _____ Date: _____

Post-Appointment Screening Checklist

POST-PROCEDURE:

1. Are you currently experiencing any redness, bruising, irritation, swelling, or other potential side effects from your recent procedure or treatment?

2. Do you have any questions regarding your recent procedure?

3. Do you have any other questions or feedback you would like to share with the office or your provider?

SYMPTOM WELLNESS CHECK:

circle answer

1. Have you experienced any of the following symptoms within the last 14 days?
   - Fever or feeling feverish ..... Yes No
   - New cough ..... Yes No
   - Shortness of breath ..... Yes No
   - Flu-like symptoms such as fatigue, nausea, diarrhea? Chills? Repeated shaking with chills? Muscle pain? Headache? Sore throat? New loss of taste or smell? Rash? ..... Yes No

   Please circle all that apply.
2. Have you been diagnosed or suspected of having Coronavirus or COVID-19? ..... Yes No
   - If yes, when? _____
3. Have you been tested for Coronavirus or COVID-19? ..... Yes No
   - If tested, was testing performed by nasal swab or blood test? _____
   - If tested, did you test: Positive or Negative _____
   - Have you had an antibody test for Coronavirus? ..... Yes No
   - If tested, did you test: Positive or Negative _____
   - If known, was the test for IgM or IgG antibodies? _____

NOTES: