Acuity Eye Group®

Our Vision is Your Vision®

Patients, please review the questions listed below. If you respond YES to any of these questions, please inform our front desk immediately.

Covid-19 Questionnaire

1. Have you had any of the following symptoms:

Fever:	YES ___	NO___
Cough:	YES___	NO___
Sore Throat:	YES___	NO___
Shortness of Breath:	YES___	NO___
Unusual Headache:	YES___	NO___
Loss of appetite:	YES___	NO___
Loss of Smell:	YES___	NO___

2. Have you been exposed to someone with known case of COVID-19 or someone with flu-like symptoms? Yes ___No___

3. Have you traveled outside the state of California or outside the USA in the past 14 days? YES___ NO___

   For Question #3 Only: If Patient believes their particular travel has not increased their risk of infection, the provider may evaluate the patient's risk and make the final determination to see or reschedule.