BRUMMITTE DALE WILSON, M.D. & ASSOCIATES
DERMATOLOGY, MOHS SURGERY, AESTHETIC & LASER SURGERY
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Certified by the American Board of Dermatology

COVID-19 Screening Form

Patient Name ____ **Date** ____/____/________

Patient Signature ____

1. **Have you tested positive for COVID-19?** ❑ **YES** ❑ **NO**
   IF YES, when? ____/____/______

2. **Have you been FULLY vaccinated for COVID-19?** ❑ **YES** ❑ **NO**
   Fully vaccinated is defined as at least 2 weeks since the last dose in the series (1-dose for J&J/Janssen, 2-doses for Moderna or Pfizer.BioNTech)
   If YES, which Manufacturer? ❑ **J&J/Janssen** ❑ **Moderna** ❑ **Pfizer/BioNTech** ❑ **Other** __________

3. **Have you been in contact with anyone who currently has COVID-19 or is under Quarantine for COVID-19 in the past 14 days?** ❑ **YES** ❑ **NO**

4. **Have you had the following symptoms within the past 14 days?**

Newly Developed Cough	❑ **YES**	❑ **NO**
Shortness of Breath	❑ **YES**	❑ **NO**
Loss of Taste or Smell	❑ **YES**	❑ **NO**
Chills / Shaking with Chills	❑ **YES**	❑ **NO**
"Flu like symptoms" *(Headache, Muscle Pain, Sore Throat)*	❑ **YES**	❑ **NO**

5. **Have you had a fever of 100.4 or higher in the past 3 days?** ❑ **YES** ❑ **NO**

6. **Have you travelled Internationally within the past 14 days?** ❑ **YES** ❑ **NO**
   IF YES when did you return to NYS? ____/____/_______
   Please list which Countries you've travelled to ____

   ____

Office Use Only
Temperature assessment to be completed at the facility before taken to a room

Temperature _________ ❑ Pass ❑ Fail

❑ Nurse Initials __________ Date ___/___/______

Covid-19 Screening Form rev 2021-06-17 BDW/msl © 6/17/2021

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