Williamson Eye Group, PC
dba Eyedentity Eyecare
Vaccinated Individual Screen
Date of Last Vaccine:_____

Intake COVID-19 Screening Questionnaire for all patients and others allowed building access:

i. Optometric practices should screen patients, visitors and staff members for symptoms of COVID-19 prior to and/or upon their arrival at the facility, including utilizing non-contact temperature readers. The CDC defines a fever as a temperature at or above 100.4°F.

1. Have you had COVID-19? Y/N Date:_____
2. Have you tested positive for COVID-19 in the last 30 days?
3. Do you have a cough?
4. Do you have shortness of breath?
5. Have you had a fever in the last 48 hours?
6. Have you had vomiting or diarrhea in the last 24 hours?
7. Do you have chills, shaking with chills, muscle pain, headache or sore throat?
8. Do you have loss of taste or smell?

I have read the above questions and answered all questions.

Patient signature/date/time of visit:

_____