Welcome to Bee Cave Dermatology – To protect you, our patients and staff please answer all the questions, sign and date. We will take your temperature and take you to your room.

Please circle Yes or No

Yes No Have you had the COVID vaccine - if yes 1 shot 2 shots

Yes No Have you had and recovered from COVID 19?

If yes when____

Yes No Have you been exposed or had contact with a COVID 19 patient?

If yes, have you had a negative COVID test and when? ______________

Yes No Have you been to a mass gathering of more than 10 people?

If yes: when_____________ where____________________

What occasion_____________________________________

Circle -- gathering was inside outside

Everyone wore masks yes no

Yes No Do you have a fever, cough, shortness of breath, sore throat?

Yes No Do you have loss of taste or smell?

Yes No Do you have diarrhea, nausea, vomiting, stomach pain?

Yes No Have you travelled outside the Austin area? If yes explain_________________

Printed Name____

Signature or (legal guardian signature if under 18 years of age or not capable of signing)

____

Patient temperature____

Date and staff initial____