<u>Welcome to Bee Cave Dermatology</u> – 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 and recovered from COVID 19?

If yes when____

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

If yes explain____

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

If yes explain and when____

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 **<u>or</u>** legal guardian signature if under 18 years of age or not capable of signing

____

Patient temperature **(for office use only)** __________________

Date____