SKIN | FACE | BODY

6 Exchange Street Norwich, NR2 1AT

PRE-APPOINTMENT WELLNESS SCREENING CHECKLIST

Patient Name_________________________________ Date of Birth_______________________________

SYMPTOM CHOICE

1) Have you experienced ANY of the following symptoms within the last 14 days?

SYMPTOM	**YES**	**NO**
Temperature or feeling feverish		
New Cough		
Sore throat		
Flu -like symptoms such as fatigue/headache		
Nausea or Diarrhoea		
Chills or shivering		
Muscle pains or rash		
Loss of Taste OR smell		

2) Have you been diagnosed or suspected of having COVID-19 YES ☐ NO ☐

Have you had a positive throat or nasal swab? ____________________________________

Date of Test ____________________________________

Have you had an antibody test? ____________________________________

Date of Test ____________________________________

FAMILY AND CLOSE CONTACTS

1) Are any of your family members or immediate/close contacts currently sick or experiencing:

   Fever, cough, shortness of breath or flu like symptoms? YES ☐ NO ☐

   Sore throat, Muscle aches, Fatigue, Nausea or Diarrhoea? YES ☐ NO ☐

2) Have any of your family members or immediate close/contacts been diagnosed with COVID19?

   If yes, where and when?_________________________________

RECENT TRAVEL

- Have you recently travelled internationally, travelled within the UK or attended public event in the last 15 days?

  If yes, where and when?_________________________________

PATIENT NAME (PRINT)___________________________________

PATIENT SIGNATURE______________________________________ DATE_______________________________