

Dear Valued Patient of **MY EYECARE**

To comply with CDC recommendations, all patients are required to complete a COVID-19 screening prior to their scheduled appointment. This will also include a non-contact temperature reading at the time of the appointment. Please complete the questionnaire below. If there are any changes prior to your appointment, please inform our staff at **321-351-4499**

	Yes	No
Have you tested positive for COVID-19?	_____	_____
Are you currently waiting for COVID-19 test results?	_____	_____
To the best of your knowledge, have you been in contact with anyone who has tested positive for COVID-19 within the last 2 weeks?	_____	_____
Do you have any COVID-19 related symptoms such as fever, fatigue, cough, shortness of breath, or loss of taste and smell?	_____	_____
Have you traveled out of the country within the last 14 days?	_____	_____
Date of Completion: / /		

Thank you for your time and patience. The completion of paperwork prior to your appointment has enabled us to streamline your exam and focus on your vision and eye health.

We look forward to seeing you,  
The Doctors and Staff at **MY EYECARE**