Houston
Hand & Foot
Orthopedics

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Orthopedic Surgery | Hand & Upper Extremity Surgery |
Foot & Ankle Surgery

COVID-19 RISK ASSESSMENT

PATIENT NAME: _____ DOB: _____ TEMP: _____

FAMILY MEMBER : _____ TEMP: _____

PATIENT SIGNATURE: _____ DATE: _____

- **HAVE YOU TRAVELED OUTSIDE OF THE COUNTRY IN THE PAST 14 DAYS? YES / NO**
- **HAVE YOU BEEN IN CONTACT WITH ANYONE WHO HAS TRAVELED OUTSIDE THE COUNTRY IN THE PAST 14 DAYS? YES / NO**
- **HAVE YOU BEEN IN CONTACT WITH SOMEONE WHO HAS TESTED POSITIVE FOR COVID IN THE PAST 14 DAYS? YES / NO**
- **HAVE YOU EXPERIENCED OR BEEN AROUND ANYONE WHO HAS THESE SYMPTOMS IN THE LAST 14 DAYS? YES/NO**

CIRCLE ALL THAT APPLY
TEMP OVER 100 F

COUGH / SHORTNESS OF BREATH / SORE THROAT

LOSS OF TASTE OR SMELL

NAUSEA / DIARRHEA

IF SO PLEASE EXPLAIN

_____

WERE YOU WEARING PROTECTIVE EQUIPMENT/COVERING? YES / NO