Dirk R. Diefendorf, M.D.
ORTHOPEDIC SURGERY - SPORTS MEDICINE

Coronavirus Screening /COVID-19

All patients and visitors will be required to wear a face mask

Please checkmark next to your answer

1) Have you traveled outside of the United States in the past 30 days? YES ☐ NO ☐
Have you been on an airplane in the last 30 days? YES ☐ NO ☐

2) Have you had any contact with anyone with confirmed COVID-19
In the last 30 days? YES ☐ NO ☐

3) Have you had any of these symptoms in the last 30 days or are you experiencing any of these symptoms currently?

Fever greater than 100, difficulty breathing, cough, Muscle aches,
fatigue, sore throat, any general flu like symptoms?

YES ☐ NO ☐

If YES please list your

symptoms:_____

If you answered no to questions 1 and 2, but yes to number 3

Please contact your primary healthcare provider.

Name:_____

Date:_____

Signature:_____