TROY M. LAMAR, M.D., F.A.C.S.

General Surgery | Advanced Laparoscopic Surgery | Bariatric Surgery

COVID-19 SCREENING FORM

Patient Name:	Date of Birth:
Signature:	Today’s Date:

Have you or anyone you are in close contact with…

Been in contact with anyone that has been diagnosed or is being monitored for COVID-19 in the last 30 days?	Yes	No
Traveled out of the USA in the last 30 days?	Yes	No
Traveled within the USA in the last 30 days?	Yes	No

If yes, where did you/they visit? ____

Attended any events or gatherings with more than 10 people?	Yes	No

Are you/they currently experiencing any of the following symptoms?

Fever of 100.4°F or higher, chills, or sweating	Yes	No
A cough or sore throat	Yes	No
Chest pain or pressure	Yes	No
Shortness of breath or difficulty breathing	Yes	No
Severe headaches	Yes	No
Muscle pain/weakness or body aches	Yes	No
Diarrhea or vomiting	Yes	No

I have been tested for COVID-19 Date(s): ___________________ Result(s): ___________________

51 North Fifth Avenue, Suite 202, Arcadia, California 91006 | Telephone: 626.445.0600 | Facsimile: 626.574.8654 | www.cbgsa.net