Lasting Impression
CORRECTIVE SKIN CARE

Patient Name: _____ Date: _____

Pre-Screening ☐ In-Office Screening ☐

Wellness Screening Checklist

SYMPTOM WELLNESS CHECK:

circle answer

1. Have you experienced any of the following symptoms within the last 14 days?
   - Fever or feeling feverish _____ Yes ☐ No ☐
   - New cough _____ Yes ☐ No ☐
   - Shortness of breath _____ Yes ☐ No ☐
   - Flu-like symptoms such as fatigue, nausea, diarrhea? Chills? Repeated shaking with chills? Muscle pain? Headache? Sore throat? New loss of taste or smell? Rash? _____ Yes ☐ No ☐
     Please circle all that apply.
2. Have you been diagnosed or suspected of having Coronavirus or COVID-19? _____ Yes ☐ No ☐
   - If yes, when? _____
3. Have you been tested for Coronavirus or COVID-19? _____ Yes ☐ No ☐
   - If tested, was testing performed by nasal swab or blood test? _____
   - If tested, did you test: Positive or Negative _____
   - Have you had an antibody test for Coronavirus? _____ Yes ☐ No ☐
   - If tested, did you test: Positive or Negative _____
   - If known, was the test for IgM or IgG antibodies? _____

FAMILY AND CLOSE CONTACTS:

circle answer

1. Are any of your family members or immediate/close contacts currently sick or experiencing fever, cough, shortness of breath, or flu-like symptoms (sore throat, muscle aches, fatigue, nausea and diarrhea)? _____ Yes ☐ No ☐
2. Have any of your family members or immediate/close contacts been diagnosed with Coronavirus or COVID-19? _____ Yes ☐ No ☐
   - If yes, when? _____

RECENT TRAVEL:

circle answer

1. Have you recently travelled in the U.S. or internationally? _____ Yes ☐ No ☐
   - If yes, where and when? _____
2. Have any of your family members recently travelled in the U.S or internationally? _____ Yes ☐ No ☐
   - If yes, where and when? _____

Vaccination Status: (Please circle your vaccination and list all vaccination dates:

Johnson & Johnson Moderna Pfizer Dates: _____

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