WONGU Health Center

Visitor Pre-Screening Questionnaire

To ensure the safety of our patients and staff, all visitors entering this facility are required to complete the following questionnaire prior to their visit.

Please check the corresponding box for the following questions that apply to you. All questions must be answered.	**YES**	**NO**
Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?	☐	☐
Have you or anyone in your household been tested for COVID-19?	☐	☐
Have you or anyone in your household traveled in the U.S. in the past 21 days?	☐	☐
Have you or anyone in your household traveled overseas or been on a cruise ship in the last 21 days?	☐	☐
Are you or anyone in your household a health care provider or emergency responder?	☐	☐
To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?	☐	☐

Do you acknowledge you have answered all questions truthfully?

Visitor's Name:	Signature:	Date of entry: