LIVE HEALTHY IMAGING

6565 West Loop South, Suite 100
Bellaire, TX, 77401
Tel: 832 344 3512 Fax: 832-895-7398

Patient Name: _____ DOB: _____

Please Check yes or no to the questions:

1. 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?	Yes ☐ No ☐
2. Have you or anyone in your household been tested for COVID-19? If your answer is Yes to this question was anyone positive?	Yes ☐ No ☐
3. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?	Yes ☐ No ☐
4. Have you or anyone in your household traveled in the U.S. in the past 21 days?	Yes ☐ No ☐
5. Have you or anyone in your household traveled on a cruise ship in the last 21 days?	Yes ☐ No ☐
6. Are you or anyone in your household a health care provider or emergency responder?	Yes ☐ No ☐
7. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? If your answer to this question is yes when did they test positive? Date:_____	Yes ☐ No ☐
8. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? If your answer to this question is yes Date: _____	Yes ☐ No ☐
9. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?	Yes ☐ No ☐

Print Name: _____

Patient Signature: _____

Date: _____

Office use only:
Patients Temperature: _____ Date: _____ Employee Initials:_____