Gynemed Surgical Center

Name: _____ **DOB:** ____/____/____

Date: _____

Screening checklist for COVID-19

At Gynemed Surgical Center our mission is to provide a safe and healthy environment for all of our guests and staff. In order to accomplish our mission, we are asking that all patients answer the following questions.

1. Have you tested positive for COVID-19? YES_____, NO_____. If yes, when

2. Have you been in close contact with someone that tested positive for COVID-19?
YES NO_____. If yes, when _____

3. Do you have, or in the last two weeks had any flu-like symptoms (cough, runny nose, fever, shortness of breath, body aches)? YES_____, NO_____. If yes, when and how long have you had the symptoms?_____

4. Have you been in close contact with someone that has flu-like symptoms? YES_____, NO_____. If yes, when_____

17 Fontana Lane ✧ Suite 201 ✧ Baltimore, Maryland 21237
(410) 391-1000 ✧ (800) 696-3004 ✧ Fax (410) 686-9057
www.gynemed.org