[COMPANY NAME]
VISITOR QUESTIONNAIRE

1. Do you currently have symptoms such as fever, chills, sweats or a temperature that is elevated for you or is 100°F or greater?
2. Do you currently have symptoms such as cough, shortness of breath, chest tightness, vomiting, nausea or sore throat?
3. In the past 14 days, have you had close contact with an individual diagnosed with COVID-19?
4. In the past 14 days, have you traveled on an airplane internationally or domestically?

If the answer to any of these questions is "yes," then for the safety of others, you may not visit our office. If all of the answers are "no," please sign in below.

Date:	Print Name:	I'm here to see:	Signature: