Clinic: Towers Audiology Center 8631 W Third St. #312E
Los Angeles, CA 90048
(310) 652-4327 Fax (310) 652—7900

Date:

COVID-19 PRE-VISIT SURVEY

Have you been vaccinated against COVID-19? Yes No

If so, which vaccine did you receive?

Booster:

Date of first vaccination:

Date of second vaccination, if applicable:

Please indicate if you are experiencing any of the following symptoms:

Yes No Do you have a fever now or have you within the last 14 days?

Yes No Do you have a cough?

Yes No Have you been in contact with a confirmed COVID-19 patient in the last 14 days?

Yes No Are you experiencing shortness of breath or difficulty breathing?

Yes No Are you experiencing flu-like symptoms such as gastrointestinal upset, headache, or fatigue?

Yes No Have you experienced recent loss of taste or smell?

By signing below, you are attesting that everything you stated above is truthful and accurate to the best of your knowledge.

Patient Name: ____ DOB: _____________________

Signature: ____