Downtown Dermatology

291 Broadway, Suite 1803
New York, NY 10007

Ph. (212) 233-2995
Fax. (212) 227-6577

Date: _____

Patient Name: _____

Patient Date of Birth: _____

1. Have you traveled outside the United States in the past 14 days (2 weeks)? If yes, please list countries: _____	□ YES	□ NO
2. Has a close contact (household member) traveled outside the United States in the past 14 days? If yes, please list countries: _____	□ YES	□ NO
3. Have you had close contact with a person with Coronavirus (COVID-19), Middle Eastern Respiratory Virus (MERS), Ebola/Lassa/Marburg, Measles, Mumps, Chickenpox, or any other known infectious disease?	□ YES	□ NO
4. Do you have a fever (temperature of 100.4ºF [38C]) or feel hot?	□ YES	□ NO
5. Do you have a cough, shortness of breath, sore throat?	□ YES	□ NO
6. Are you vomiting or have diarrhea?	□ YES	□ NO
7. Do you have any rash?	□ YES	□ NO

If you answer YES to any part of question 1, and YES to any other question, please notify the staff immediately for further instructions.