

Mr. / Ms. ....

appointment on ..... at .....

with Dr ..... for a medical visit.

In order to ensure your safety and ours, we have to take several precautions, **therefore we kindly ask you to answer several COVID-19-related questions before seeing the physician.**

**please read the questions very carefully before circling your answer:**

**a. Do you have any of the following symptoms: fatigue, malaise, body aches, headache, fever, cough, sore throat, diarrhea, difficulty breathing, nasal congestion, runny nose, chest tightness, altered sense of smell or taste**

YES / NO

b. **Have** you had any of the above symptoms in the past 2 weeks?

YES / NO

c. **Has anyone in your family, or other people you have been in contact with,** had any of the above symptoms in the past 2 weeks?

YES / NO

d. Have you been in contact with confirmed or suspected cases of covid-19 in the past 2 weeks?

YES / NO

e. Have you **been outside the Lazio Region** in the last 14 days?

YES / NO

**If so, where?**

**We inform you that if you answer positively to one or more of the questions, you might not be allowed to stay at the medical office and you will get in touch over the phone with your specialist.**

Signature