Coronavirus Patient Questionnaire For Perfect Image Consultants
Please note, as a safety measure, we require the following information:

SURNAME		FIRST NAME
APPT	OVER 18?	REPEAT PATIENT?

Have you returned from abroad in the last 14 days? If yes, please circle.			YES	NO
TRAVEL ZONE	GREEN	AMBER	RED	
ARE YOU REQUIRED TO ISOLATE?	NO	YES – UNTIL WHEN?		
ARE YOU VACCINATED?	NO	ONE DOSE	DOUBLE DOSE	

Have you experienced any of the coronavirus symptoms in the last two weeks? If yes, please circle.		YES	NO
NEW AND CONTINOUS COUGH	HIGH TEMPERATURE		
LOSS OF SMELL / TASTE	CHANGE TO SMELL / TASTE		

Have you had or been in contact with anyone who has had a confirmed case of coronavirus?	YES	NO

Please note as we are a healthcare facility and in the interest of our patients and staff:- • **Patients must attend their appointment wearing a face covering** • **Patients must attend their appointments alone where possible** • **Patient must wash their hands and their temperature will be taken on arrival**	YES	NO

Date of questionnaire		Completed by	

I hereby declare that the above information is correct as at today's date. **I understand that the clinic has done all it can to protect both patients and staff from Covid-19 and am aware that I am here by choice and the clinic cannot be held responsible in the event that I contract Covid-19.**	YES	NO

PATIENT SIGNATURE:	**DATE:**

Temperature on arrival	**Time Taken**	**Taken By (Name and Sign)**
Please ask patient to wash hands as per guidelines		