Focal Point Vision
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COVID-19 Preop Screening Questionaire

Patient Name: _____

Date of Birth: _____

Date of Surgery: _____

Questions		
1. Have you and/or your responsible adult traveled outside the USA? Outside of Texas in the last 14 days? If so where?	YES	NO
2. Have you and/or your responsible adult been in close contact with a person known to have tested positive for COVID-19?	YES	NO
3. Do you and/or your responsible adult currently have a fever or respiratory symptoms (cough or shortness of breath)?	YES	NO

Patient concerns or questions:

Form completed by: _____ Date: _____