SAN BERNARDINO COUNTY | Public Health
Environmental Health Services

Facility Name:
Address:
Telephone Number:

# Supplemental Medical Questionnaire

This questionnaire is intended as a supplemental screening tool to be used in addition to the standard medical questionnaire completed by the client prior to a body art procedure.

Client name: _____

Date: _____

**Have you recently experienced any of the following?**

| *Yes* | *No* | |
|---|---|---|
| ☐ | ☐ | Fever |
| ☐ | ☐ | Shortness of breath |
| ☐ | ☐ | Cough |
| ☐ | ☐ | Chills |
| ☐ | ☐ | Repeated shaking with chills |
| ☐ | ☐ | Muscle pain |
| ☐ | ☐ | Headache |
| ☐ | ☐ | Sore throat |
| ☐ | ☐ | New loss of taste or smell |
| ☐ | ☐ | Other _____ |

_____

***If you have one or more symptom(s) that may be related to COVID-19 we urge you to return home and contact your medical provider.***

If you are experiencing **emergency warning signs** for COVID-19, seek **medical attention immediately**.

Emergency warning signs include; trouble breathing, persistent pain or pressure in the chest, new confusion or unable to be woken, and bluish face/lips.

**In the last two weeks, have you?**

| *Yes* | *No* | |
|---|---|---|
| ☐ | ☐ | Had contact with someone diagnosed with COVID-19? |
| ☐ | ☐ | Have you been tested for COVID-19? Date_____ |
| ☐ | ☐ | If yes, have you had subsequent negative COVID-19 test results? Test date(s)_____ |

# Daily Cleaning and Sanitation Log

Facility: _____ Week of: _____

| Date | Time | Waiting Area | Procedure Area | Decontamination Area | Restroom | Front Counter | Other | Disinfectant Used | Cleaned By |
|---|---|---|---|---|---|---|---|---|---|
| *5/20/2020* | *8:00 AM* | x | x | x | x | x | x | *Cavicide* | *John Doe* |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | |

# Daily Sign in Sheet

**Facility:**_____**Date:**_____

| Full Name(Practitioner/client/ visitor) | Time in | Time Out | Reason for Visit/with whom | Temp. |
|---|---|---|---|---|
| *Jane Doe* | *8:00 AM* | *12:00 PM* | *Tattoo by Manny* | *97.7F* |
| *Practitioner Name* | *12:00 PM* | *9:00 PM* | *Work* | *98.6F* |
| | | | | |
| | | | | |
| | | | |