COVID-19 SCREENING QUESTIONNAIRE

To reduce the spread of COVID-19, please respond to the screening questions below. For the safety of yourself, our staff, and other patients, please be truthful in your answers.

General Information

TODAY'S DATE: ______________ **NAME:** ______________________________

Question	YES	NO
Has the patient or anyone in the same household been tested positive for COVID-19 in the last 30 days?	YES ○	NO ○
Are you or anyone in the same household currently awaiting the results of a COVID19 test result?	YES ○	NO ○
Has the patient been exposed to anyone confirmed positive with COVID-19 and has been quarantined in the last 30 days?	YES ○	NO ○
Is the patient having shortness of breath or difficulties breathing?	YES ○	NO ○
Does the patient have a cough?	YES ○	NO ○
Has the patient experienced any of the following symptoms? Such as, fever, headache, fatigue, nasal congestion, upset stomach, sore throat, runny nose, or sneezing?	YES ○	NO ○
Has the patient experienced any recent loss of taste or smell?	YES ○	NO ○
Has the patient traveled anywhere in the US or outside in the US in the last 14 days?	YES ○	NO ○

***** ANSWERING "YES" TO ANY OF THESE QUESTIONS WILL LIKELY INDICATE A NEED FOR A DEEPER DISCUSSION WITH OUR FRONT DESK STAFF BEFORE BEING SEEN BY MEDICAL PERSONNEL AND POSSIBLY A RESCHEDULING OF YOUR APPOINTMENT. THIS IS TO ENSURE THE SAFETY OF OUR OFFICE STAFF AND OTHER PATIENTS. WE APPRECIATE YOUR PATIENCE AND UNDERSTANDING DURING THESE UNPRECEDENTED TIMES. *****

Signature of Patient/Legal Guardian ______________ Date ______________

Submit