COVID-19 Screening Questionnaire:

Date: _____ Initial: _____ Temp: _____

Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?

Yes ☐ No ☐ Fever (100.4° F/37.8° C or greater as measured by a thermometer)

Yes ☐ No ☐ Cough

Yes ☐ No ☐ Shortness of breath or difficulty breathing

Yes ☐ No ☐ Sore throat

Yes ☐ No ☐ New loss of taste or smell

Yes ☐ No ☐ Chills

Yes ☐ No ☐ Head or muscle aches

Yes ☐ No ☐ Nausea, diarrhea, vomiting

In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?

Yes ☐ No ☐ In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?

Yes ☐ No ☐ Have you been tested for COVID-19 and are waiting to receive test results?

Yes ☐ No ☐ In the past 14 days, have you been on a commercial flight or traveled outside of the United States?

Yes ☐ No ☐ Have you visited a Nursing facility in the last 2 Weeks?

You must let us know if you develop the Coronavirus in the next 14 days!

Any "Yes" Answer(s) May Require Rescheduling today's "In Office" Appointment.