COVID-19 SCREENING

Patient Name: ____ Date: _____________

	Visit Date											
Indicate Yes or No to the following:	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Do you have a fever, or have you felt feverish recently?												
Do you have a cough?												
Are you having shortness of breath or any difficulty breathing?												
Do you have the chills or repeated shaking with chills?												
Do you have muscle pain?												
Do you have any recent onset of headache or sore throat?												
Do you have any other flu like symptoms?												
Do you have any recent loss of taste or smell?												
Have you experienced any recent GI upset or diarrhea?												
Are you in contact with anyone who has been confirmed to be COVID-19 positive?												
Have you traveled in the past 14 days to any regions affected by COVID-19?												
Have you been tested for COVID-19? If Yes, what was your result?												
Have you been diagnosed with COVID-19? If Yes, When?												

The Staff will perform a Temperature check upon entering the facility.

Temperature (° F)						
Staff Initial						
Patient Initial						