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COVID-19 Screening Form

Patient Name: _____ Date: _____

Please Answer the Following Questions to the Best of Your Knowledge:	Circle Yes or No	If Yes Please Explain
Do you have a fever or have you felt feverish recently?	YES NO	
Are you having shortness of breath, or other difficulties breathing, or a cough?	YES NO	
Do you have any other flu-like symptoms, such as gastrointestinal upset, headache, fatigue?	YES NO	
Have you experienced a recent loss of taste or smell?	YES NO	
Have you been tested for COVID-19 or had an antibody test?	YES NO	
Have you been/Are you in close contact with anyone confirmed positive for COVID-19 within the last 14 days?	YES NO	
Have you traveled outside the US by air or cruise ship in the past 14 days?	YES NO	
Have you traveled within the US by air, bus or train within the past 14 days?	YES NO	

Patient Signature: _____

Print Name: _____

If someone other than patient is signing please indicate relationship to patient: _____