Name: ___________________ Date: __________________

COVID-19 Screening Questionnaire

1. Have you traveled to any of these locations in the last 14 days?

Alabama Y N
Arkansas Y N
Arizona Y N
California Y N
Florida Y N
Georgia Y N
Idaho Y N
Louisiana Y N
Mississippi Y N
North Carolina Y N
Nevada Y N
South Carolina Y N
Tennessee Y N
Texas Y N
Utah Y N

Anywhere else outside of the US? Y N location(s)

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Anywhere else within the continental US? Y N location(s)

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2. Have you had any type of contact with anyone with confirmed COVID-19 in the last 14 days? Y N

3. Have you had any of these symptoms in the last 14 days?

Fever greater than 100° Y N
Difficulty breathing Y N
Cough Y N
Loss of smell Y N
Loss of taste Y N

4. Are you currently experiencing:

Fever greater than 100° Y N
Difficulty breathing Y N
Cough Y N

I certify that my answers above are accurate and truthful

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Patient Signature