Name: __________________ Date: _________________

COVID-19 Screening Questionnaire

1. Have you traveled:

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