Covid-19 Screening Questionnaire

Patient Full Name: **Date of Birth:**

Please answer the following questions to the best of your knowledge:

	Yes	No
1. Do you or have you had any flu-like symptoms in the last 14 days?	☐	☐
• New onset of Cough or Worsening chronic cough.	☐	☐
• Shortness of Breath or Difficulty Breathing	☐	☐
• Difficulty Swallowing	☐	☐
• Fever	☐	☐
• Chills	☐	☐
• Headaches	☐	☐
• Sore throat	☐	☐
• Decrease or loss of sense of taste or smell	☐	☐
• Unexplained fatigue/malaise/muscle aches (myalgias)	☐	☐
• Nausea/vomiting, diarrhea, abdominal pain	☐	☐
• Pink eye (conjunctivitis)	☐	☐
• Runny nose/nasal congestion without other known cause	☐	☐
2. Are you awaiting results of a lab test for COVID-19?	☐	☐
3. Have you tested positive for COVID-19? When?	☐	☐
4. Have you or a family member previously been asked to self-isolate or self-quarantine in the past 14 days?	☐	☐
5. Have you had close contact to an individual diagnosed with COVID-19 infection in the past 14 days?	☐	☐
6. Have you traveled in the past 14 days to a region with high rates of COVID-19 disease activity?	☐	☐

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Patient Signature: Date:

SUBMIT