COVID-19 Screening Questionnaire

To be completed by parent or guardian unless the patient is over 18

1. Have you within the last fourteen (14) days traveled to a country where community-based spread of COVID-19 is occurring or to any other geographic region in the United States with sustained community transmission of COVID-19?
   Yes _____ If yes, please indicate date/location: _____
   No _____

2. Have you had direct contact within the last fourteen (14) days with a person confirmed or suspected to be positive with COVID-19?
   Yes _____
   No _____

3. In the last fourteen (14) days, have you been in close contact with anyone who has experienced any of the following cold or flu-like symptoms – fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, lack of taste or smell, gastrointestinal upset, or fatigue?
   Yes _____
   No _____

4. Do you have, or have you experienced the following cold or flu-like symptoms within the last fourteen (14) days – fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, lack of taste or smell, gastrointestinal upset, or fatigue?
   Yes _____
   No _____

5. Have you been tested for COVID-19?
   Yes _____ If yes, please indicate the date of test and result: _____
   No _____

Patient's Name_____

Person Completing the Form (if other than the patient) _____

Signature of Patient/Parent/Guardian _____ Date _____

----------*To be completed by the office*----------

Patient's Temperature: _____ *F / C* (will be taken at the office)

Name of Person Bringing Patient: _____

Temperature of Person Bringing Patient: _____ *F / C*

**For the safety of other patients and our team, please notify our office if anyone in your household displays COVID-19 symptoms or tests positive for COVID-19 in the next 14 days.*