COVID-19 Screening Questionnaire

STOP!

If you are experiencing cold or flu symptoms like:

- **Fever**
- **Cough**
- **Shortness of breath**

REPORT IMMEDATELY to the registration desk.

Name: ____ Today's Date: __________

Date of Birth: ______________ Temperature: __________

1. Have you been diagnosed or been in close contact (less than 6 feet) with someone who is suspected/diagnosed with COVID-19 in the past 14 days? **Yes No**

2. Have you attended any large or small events or gatherings with more than 6 people within the past 14 days? **Yes No**

3. Do you have any of the following within the last **48 hours**:

☐ Fever, chills or inexplicable sweating
☐ Cough
☐ Shortness of breath or difficulty breathing
☐ Muscle or body aches
☐ Headache
☐ Loss or altered sense of taste or smell
☐ Sore throat
☐ Runny or stuffy nose
☐ Fatigue or malaise
☐ Nausea, vomiting or diarrhea
☐ **None of the above**

Recommendations to mitigate contracting and spreading COVID-19 are to

- *observe social distancing,*
- *correctly wear facemasks,*
- *practice proper hygiene,*
- *and watch for symptoms.*

Thank you for helping us protect other patients and staff.

Patient's Signature______________________________