

## COVID-19 PATIENT SCREENING QUESTIONNAIRE

\*Indicate Yes or No and provide relevant comments.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Screening Questions	Yes	No
1. Do you have a fever, or have you felt feverish recently?		
2. Do you have a cough?		
3. Are you having shortness of breath or any difficulty breathing?		
4. Do you have chills or repeated shaking with chills?		
5. Do you have any muscle pain?		
6. Do you have any recent onset of headache or sore throat?		
7. Do you have any other flu-like symptoms?		
8. Do you have any recent loss of taste or smell?		
9. Have you experienced any recent GI upset or diarrhea?		
10. Are you in contact with anyone who has been confirmed to be COVID-19?		
11. Have you been tested for COVID-19?		
If yes, what was the result?		
12. Have you been diagnosed with COVID-19?		
If yes, when?		