COVID-19 PATIENT SCREENING QUESTIONNAIRE
Patient Name: ____ DOB: __________________

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? Fever or feeling feverish ☐ Yes ☐ No
2. Cough ☐ Yes ☐ No
3. Shortness of breath or difficulty breathing ☐ Yes ☐ No
4. Sore throat ☐ Yes ☐ No
5. New loss of taste or smell ☐ Yes ☐ No
6. Chills ☐ Yes ☐ No
7. Head or muscle aches ☐ Yes ☐ No
8. Nausea, diarrhea, vomiting ☐ Yes ☐ No
9. In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? ☐ Yes ☐ No
10. In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? ☐ Yes ☐ No.
11. Have you been tested for COVID-19? ☐ Yes What was the result? _________________________________ Date you were tested _________________________________ ☐ No
12. . In the past 14 days, have you been on a commercial flight or traveled outside of the United States? ☐ Yes ☐ No
13. Are you fully vaccinated for COVID-19 ☐ Yes ☐ No?

    I refuse vaccination ☐
    I don't qualify for vaccination ☐

Certification

Please return this form to the front desk when completed By signing below, you certify that the answers above are true. Failure to answer truthfully or withholding information intentionally will lead to immediate dismissal from our practice and may be subject to applicable laws during this pandemic.

____________________	______________________	__________
Printed Name	Signature	Date