COVID-19 Patient Screening Form

PATIENT NAME:		
	Before Appointment	**In-Office Appointment**
	DATE:	**DATE:**
Are you over 60 years of age?	YES / NO	YES / NO
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease, or an autoimmune disorder?	YES / NO	YES / NO
Are you experiencing shortness of breath or trouble breathing?	YES / NO	YES / NO
Do you have a temperature of 100.4° F or higher?	YES / NO	YES / NO
Are you experiencing a sore throat?	YES / NO	YES / NO
Are you coughing?	YES / NO	YES / NO
Are you experiencing repeated shaking with chills?	YES / NO	YES / NO
Do you have muscle aches?	YES / NO	YES / NO
Are you experiencing gastrointestinal changes?	YES / NO	YES / NO
Have you noticed a loss of smell or taste?	YES / NO	YES / NO
Have you had contact with a known or suspected COVID-19-positive person?	YES / NO	YES / NO
In the last 14 days, have you traveled to an area that has a high incidence of COVID-19?	YES / NO	YES / NO
If YES to the previous question, please specify where:		