Patient Screening Form

Patient Name:

	Pre-Appointment	In-Office
	Date:	Date:
Do you/ they have a fever or have you/ they felt hot or feverish recently (14-21 days)?	○ Yes ○ No	○ Yes ○ No
Do you/they have a cough, difficulties breathing or shortness of breath?	○ Yes ○ No	○ Yes ○ No
Have you/ they experienced the recent loss of taste or smell?	○ Yes ○ No	○ Yes ○ No
Are you/ they in contact with any confirmed COVID-19 positive patients?	○ Yes ○ No	○ Yes ○ No
Do you/ they reside in a nursing home, senior living center or other type of group home?	○ Yes ○ No	○ Yes ○ No
Have you ever tested positive for COVID-19?	○ Yes ○ No	○ Yes ○ No
Any flu-like symptoms?	○ Yes ○ No	○ Yes ○ No
Have you/ they traveled by plane in the past 14 days?	○ Yes ○ No	○ Yes ○ No