Coronavirus (Covid-19) Screen

Please answer the following questions regarding COVID-19:

Have you or a family member traveled domestically or internationally in the past two weeks?

- ☐ Yes
- ☐ No
- ☐ Unknown

Have you been exposed to anyone who has tested positive for Covid-19 in the past two weeks?

- ☐ Yes
- ☐ No
- ☐ Unknown

Have you experienced any the following symptoms in the past two weeks?

☐ Cough	☐ Headache
☐ Congestion or runny nose	☐ Muscle or body aches
☐ Diarrhea	☐ Nausea or vomiting
☐ Fatigue	☐ New loss of taste or smell
☐ Fever or chills	☐ Shortness of breath/difficulty breathing
☐ Other:____________________	☐ Sore throat

Patient Name: ______________________________ Patient DOB:_____________

Patient Signature:______________________________ Date: _____________