PATIENT SCREENING FORM

To reduce the risk of spreading COVID-19, we ask you to please answer the screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

All patients must complete this form by checking "Yes" or "No" to indicate your answer to each question.

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1. **Within the last fourteen (14) days, have you or any person(s) in your household <u>experienced</u> any of the following symptoms consistent with COVID-19: Fever or Chills, Cough, Shortness of Breath or Difficulty Breathing, Fatigue, Muscle or Body Aches, Headache, New Loss of Taste or Smell, Sore Throat, Congestion or Runny Nose, Nausea or Vomiting, Diarrhea?**

   ☐ **Yes** ☐ **No**

2. **Within the last fourteen (14) days, have you or any person(s) in your household had close contact with a person confirmed to be positive with COVID-19 or anyone who has symptoms consistent with COVID-19?**

   ☐ **Yes** ☐ **No**

3. **Are you fully vaccinated?**

   ☐ **Yes** ☐ **No**

   Please note that to be considered fully vaccinated, you must be ≥2 weeks following receipt of the second dose in a two-dose series or ≥2 weeks following receipt of one dose of a single-dose vaccine.

4. **Have you or any person(s) in your household tested positive for COVID-19 or are currently awaiting test results?**

   ☐ **Yes** ☐ **No**

   If yes, please indicate:

   Date(s) and result(s) of any tests _____
   Date of symptom(s) onset _____
   Last date you had a fever above 100.0 _____
   Last date of taking medications to control fever _____

5. **Have you or any person(s) in your household been asked to self-isolate or self-quarantine due to recent travel or because of exposure to someone with COVID-19?**

   ☐ **Yes** ☐ **No**

   ****If yes, please indicate date(s):*** _____

_____ _____
Print Patient Name Responsible Party Name (if applicable)

_____ _____
Patient or Responsible Party Signature Date

Patient
Temperature

_____°F or °C

Last Updated: 6/3/2021