PATIENT Screening for COVID-19

Date:_____ **Name:** _____

Person filling out form if different and relationship: _____

Screening days before: no symptoms/clear _____ temp/other:_____

***PLEASE LIST TODAY's TEMPERATURE*:** _____ Other: _____

ANSWER ALL QUESTIONS

	Have you had any of the following symptoms **IN THE LAST TWO WEEKS?**	***NOW?***
1. Fever >100.4°F (38° C)	☐Yes ☐No	☐Yes ☐No
2. Chills	☐Yes ☐No	☐Yes ☐No
3. Acute Cough *(Or worsening of chronic cough)*	☐Yes ☐No	☐Yes ☐No
4. Shortness of Breath or Difficulty Breathing	☐Yes ☐No	☐Yes ☐No
5. Extreme Fatigue, new onset	☐Yes ☐No	☐Yes ☐No
6. Muscle or Body Aches, new onset	☐Yes ☐No	☐Yes ☐No
7. Headache-Acute, new onset	☐Yes ☐No	☐Yes ☐No
8. New Loss of smell or taste	☐Yes ☐No	☐Yes ☐No
9. Sore Throat	☐Yes ☐No	☐Yes ☐No
10. Congestion or Runny Nose	☐Yes ☐No	☐Yes ☐No
11. Nausea or Vomiting	☐Yes ☐No	☐Yes ☐No
12. Diarrhea *(≥3 loose/looser than normal stools/24hr period)*	☐Yes ☐No	☐Yes ☐No

13. **In the past 2 weeks** have you **travelled OUTSIDE your home area?** ☐Yes ☐No
    If yes, Where traveled to? _____ Dates you left and dates returned? _____ Reason: _____
    Comments on masks worn & social distancing? _____
14. Have you **travelled by airplane within the past 2 weeks** to/from ANYWHERE? ☐Yes ☐No
    If yes, **date returned** to home area? other info? _____
15. SINCE PREVIOUS RESPONSES TO OUR SCREENINGS, have you had or think you had COVID-19? ☐Yes ☐No
    If yes, date of first symptoms? _____Date symptoms resolved? _____ Still symptomatic? ☐Yes ☐No
    Current symptoms? _____Tested? ____If yes, type of test *, Date/s results:_____
16. SINCE PREVIOUS RESPONSES TO OUR SCREENINGS, have you been exposed to COVID-19? ☐Yes ☐No
    a. Date **you** were exposed_____your symptoms: _____
    Date your symptoms began _____Date symptoms resolved _____ Still symptomatic? _____
    b. Date of **other persons's** first symptoms _____Date their symptoms resolved _____Still symptomatic?_____
    c. Were **you or they Tested?** _____ List person, Date/s, type of test*, results/info:

_____

tests: answer TYPE of test: 1. Active virus present (nose/throat swab or other OR 2. Antibody (blood test)

17. If needed, list question number with explanation of all YES answers not explained above:

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