**COVID-19 Screening Form**

# Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_ (taken by):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREAPPOINTMENT CHECK IN-OFFICE VISIT**

1. Have you previously been diagnosed with COVID-19, or do you think you’ve had/have COVID-19?

YES NO YES NO

*(If NO to question 1, skip to question 5)*

1. If YES, when and how were you confirmed positive? I think I had it.

I had a positive nasal swab test. I had a positive blood test.

I had a positive saliva test.

I currently have symptoms and am waiting for a test.

1. If you have had COVID-19, how were you confirmed negative?

I was diagnosed negative by a nasal swab test. How many times? How far apart? I show antibodies to COVID-19 with a blood test.

My doctor said I no longer have it because I don’t have any symptoms. I don’t have any symptoms, so I don’t have it.

1. If you have had COVID-19, when were you confirmed negative?

24 hours ago today 10 days after testing

1. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

Fever YES NO YES NO

*If fever, how did you measure it?*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fatigue (feeling tired)Altered or loss of taste/smell | YESYES | NONO | YESYES | NONO |
| Dry cough | YES | NO | YES | NO |
| Trouble breathing | YES | NO | YES | NO |
| Shortness of breath, difficulty |  |  |  |  |
| breathing, chest tightness | YES | NO | YES | NO |
| Confusion | YES | NO | YES | NO |
| Blueish lips or face | YES | NO | YES | NO |
| Chills/repeated shaking with chills | YES | NO | YES | NO |
| Muscle pain | YES | NO | YES | NO |
| Headache or sore throat | YES | NO | YES | NO |
| Any other flu-like symptoms | YES | NO PLEASE LIST | YES | NO PLEASE LIST |
| GI upset or diarrhea | YES | NO | YES | NO |

1. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?

YES NO YES NO

1. In the past 14 days have you traveled to any regions affected by COVID-19?

YES NO YES NO

*Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:*

1. Are you over age 65? YES NO YES NO
2. Do you have high blood pressure? YES NO YES NO

*If you have high blood pressure, is it controlled?*

YES NO YES NO

1. Do you have diabetes? YES NO YES NO
2. Are you overweight? YES NO NO ANSWER YES NO NO ANSWER
3. Do you have respiratory problems? YES NO YES NO
4. Do you have any autoimmune disorders?

YES NO ` YES NO

1. Are there any other conditions you would like to report?