*Insert practice logo here*

In our continued efforts to stop the spread of COVID-19, we ask that you complete this questionnaire and provide us with the best phone number to reach you following your visit.  A member of our staff will be checking your temperature prior to you meeting with the doctor and we ask that you keep your mouth and nose covered with a mask during your visit. Feel free to use the hand sanitizer available throughout the office and if the need arises, please cough and sneeze into your elbow.

We thank you in advance for your cooperation.

1. Do you or anyone in your household currency have the following symptoms?

* Fever                                                    Yes    No
* Headache                                             Yes    No
* Runny nose and sneezing                    Yes    No
* Cough and sore throat                          Yes    No
* Difficulty breathing                                Yes    No
* Muscle pain and weakness                  Yes    No
* Chills and fatigue                                  Yes    No
* Loss of taste or smell                            Yes    No

2. Have you or anyone in your household been tested for COVID-19?

YES (who)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   NO

3. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?

YES (who) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   NO

4. Have you or anyone in your household traveled in the U.S. in the past 21 days?

YES (who and where) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   NO

5. Have you or anyone in your household traveled on a cruise ship in the last 21 days?

YES             NO

6. Are you or anyone in your household a health care provider or emergency responder?

YES (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_         NO

7. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?

YES (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     NO

8. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?

YES (explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NO

9. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?

YES                  NO

Patient printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          TEMPERATURE AT TIME OF VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_