PATIENT SCREENING FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | PRE-APPOINTMENT  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | IN-OFFICE  Date:\_\_\_\_\_\_\_\_\_\_ |
| Do you/they have a fever or have you/they felt hot or feverish recently (14-21 days)? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_No |
| Are you/they having shortness of breath or other difficulties breathing? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Do you/they have a cough? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Have you/they experienced recent loss of taste or smell? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Are you/they in contact with any confirmed COVID-19 positive patients? Do you have any family members at home with COVID-19? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Is your/their age over 60? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Do you/they have heart disease/ lung disease, kidney disease, diabetes or any auto-immune disorders? | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| Have you/they traveled in the past 14 days to any regions affected by COVID-19? (such as NY, CA, Philadelphia, Chicago) | \_\_\_ Yes \_\_\_ No | \_\_\_ Yes \_\_\_ No |
| OFFICE USE ONLY:  Staff member that completed this with patient please sign off and date. | Completed By:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_ | Completed By:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_ |