COVID-19 Screening Questionnaire

Patient Name: _____ Date: _____

	Please select one:	
Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19?	○ **YES**	○ **NO**
Have you tested positive for COVID-19 in the past 14 days?	○ **YES**	○ **NO**
Have you experienced any symptoms of COVID-19 in the past 14 days? • Fever (>100.0 °F) or chills • Cough • Shortness of breath or Difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Sudden/Active diarrhea	◉ **YES**	○ **NO**
In the past 14 days, have you traveled **internationally**?	○ **YES**	○ **NO**
If yes, did you quarantine for seven days with a test three to five days following your arrival and receive a negative test result? OR did you quarantine for the full 10 days without a test? Please note this applies to ALL international travelers whether they were tested before boarding, are recovered from a previous COVID-19 infection or are fully vaccinated.	◉ **YES**	○ **NO**
Do you have any current symptoms of illness?	○ **YES**	○ **NO**