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UPDATED 4/16/20

2019 NOVEL CORONAVIRUS DISEASE (COVID-19)
SCREENING QUESTIONNAIRE

1. Have you within the last fourteen (14) days travelled to a country where community-based spread of COVID-19 is occurring or to any other geographic region in the United States with sustained community transmission of COVID-19?

   Yes _____ If yes, please indicate date / location: _____

   No _____

2. Have you had direct contact within the last fourteen (14) days with a person confirmed or suspected to be positive with COVID-19?

   Yes _____

   No _____

3. In the last fourteen (14) days, have been in close contact with anyone who has experienced any of the following cold or flu-like symptoms – fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, or lack of taste or smell?

   Yes _____

   No _____

4. Do you currently have, or have you experienced any of the following cold or flu-like symptoms within the last fourteen (14) days – fever, cough, shortness of breath, difficulty breathing, sore throat, body aches, or lack of taste or smell?

   Yes _____

   No _____

5. Have you been tested for COVID-19?

   Yes _____ If yes, please indicate the date of test and result: _____

   No _____

Patient Temperature: _____ *F / C*

PERSON COMPLETING THE FORM (if other than the patient) _____

PATIENT NAME_____ DOB _____