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COVID 19 Patient Screening Form

Please complete the following form. Skip past the "IN OFFICE" questions as those will be completed during your exam.

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Do you have fever or have you felt hot or feverish recently (14-21 days)? * ◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

Are you having shortness of breath or other difficulties breathing? * ◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

Do you have a cough, sore throat or runny nose? * ◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? * ◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

Are you in contact with any confirmed COVID-19 positive patients?
***Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment.** *
◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

Have you traveled in the past 14 days to any regions affected by COVID-19? * ◯ Yes ◯ No

IN OFFICE ◯ Yes ◯ No

NOTE:

_____

_____

Name of patient, parent, or guardian completing this form: *

_____

_____

Relationship to patient: *

_____

_____

_____

Response Date: _____