



COVID-19 Patient Screening Form

Patient Name:

Has the patient (or someone they live with) returned from travel to a non-U.S. country in the within the last 30 days? **Yes** **No**

If yes, please name the country/countries visited: _____.

Have you been exposed, recovered from, or tested positive for COVID-19 in the last 2 weeks? **Yes** **No**

If yes, which (check all that apply):

- Exposed
- Recovered from
- Tested Positive

Do you live with someone who has been exposed or has tested positive for COVID-19 in the last 2 weeks? **Yes** **No**

Are you currently experiencing any of the following flu-like symptoms?

If yes, which (check all that apply):

- Fever
- Sore Throat, Cough
- Chills
- Shortness of breath
- Unexplained muscle pain
- Nausea, Vomiting, Diarrhea
- Runny nose
- Headache
- Loss of taste or smell

Have you been in close contact with someone who has been ill with cough and/or fever within the past 14 days? **Yes** **No**

Do you have any of the following COVID-19 health risk factors:

If yes, which (check all that apply):

- Over 65
- Heart condition
- Lung condition
- High Blood Pressure
- Immune compromised
- Diabetes
- (HIV, cancer, other)
- Pregnant

Patient temperature: _____ . Oxygen: _____ . Pulse: _____ .

I have reviewed the patient screening form and patient has been cleared to be seen today.

Patient Signature: _____ . Date: _____ .

Patient Print Name: _____ .

Signature of Employee Reviewing Form: _____ .

Employee Print Name: _____ . Date: _____ .