**COVID-19 SCREENING QUESTIONNAIRE**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you, the patient or anyone in your home been in contact with a person with known or suspected COVID-19?

❒ Yes ❒ No

1. Have you, the patient or anyone in the house traveled out of the state in the last two weeks? Where?

❒ Yes ❒ No

1. Have you or anyone in the household been in large crowds in the last two weeks?

❒ Yes ❒ No

1. Have you, the patient or anyone in the house been sick with a fever and/or cough in the past 1 week?

❒ Yes ❒ No

1. Have you, the patient or anyone in your home experienced diarrhea?

❒ Yes ❒ No

Please note that we will be checking the temperature of everyone coming into the office. Any adult with a temperature greater than 99.5° will not permitted into the office.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian/Patient Printed Name