COVID-19 Screening Survey

Patient Name: _____ Today's Date: _____

Patient's DOB: _____

1. Do you have any of the following symptoms right now? Please check all that apply.

- □ Cough
- □ Shortness of breath
- □ Chills
- □ Altered sense of taste or smell
- □ Diarrhea
- □ Fatigue
- □ Sore throat
- □ Headache
- □ Decreased appetite
- □ Fever (greater than 100.4 F)
- □ Difficulty Breathing
- □ Muscle/joint body aches
- □ Nausea
- □ Rigors (whole body shakes)
- □ Runny nose
- □ Rash
- □ Coughing up sputum

2. Have you traveled outside this community within the past 14 days? If so, where have you traveled? □ YES □ NO LOCATION: _____

3. Have you been in close contact with someone who has traveled outside of this community within the past 14 days? □ YES □ NO

4. Have you been in close contact with someone who has COVID-19? □ YES □ NO

5. Have you been in close contact with someone who has been ill with cold symptoms or with someone who has been screening for COVID-19? □ YES □ NO

6. **Females only**: Are you pregnant? □ YES □ NO