Coronavirus /COVID- 19 Patient and Visitor Screening Form

Exposure to COVID-19 is an inherent risk in any public location where people are present; we cannot guarantee you will not be exposed during your visit. We are taking every precaution to protect both you and our staff. This questionnaire is one of those measures so please complete accurately.

Patient Name: _______________________________ DOB: _________ Date: ________

Have you, the patient, or anyone in the patient's HOUSEHOLD

1) Tested positive for COVID-19 in the past **2 weeks** YES NO

2) Been in close contact with **anyone** who tested positive for COVID-19 in the **past month.**

YES NO

3) Been in close contact with anyone who is **waiting** on COVID-19 test results.

YES NO

4) Had any of the following please **check all that apply** (If present, circle if patient or household)

___ FEVER in the last 48 hours (patient / household)
___COUGH (patient / household)
___LOSS OF TASTE OR SMELL (patient / household)
___SHORTNESS OF BREATH (patient / household)
___FATIGUE (patient / household)
___MUSCLE ACHES (patient / household)

5) Has the **Patient** ***ever*** tested positive for COVID19? YES NO
..during the time of diagnosis did they have any symptoms? YES NO

if yes please describe?
____

Patient / Parent or Guardian signature: ____