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COVID-19 SCREENING QUESTIONS

Question		
Have you experienced any of the following symptoms in the past 48 hours: • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigues • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose	**YES**	**NO**
Have you or anyone in your household tested positive for- COVID 19 in the past 14 days?	**YES**	**NO**
Have you or anyone in your household been in contact with anyone who tested positive for COVID-19 in the past 14 days?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test?	**YES**	**NO**
Have you traveled outside the US in the past 14 days?	**YES**	**NO**
Have you had the COVID-19 Vaccine (both doses)?	**YES**	**NO**

Today's Date: ____

Patient signature: ____

Print name: ____