PATIENT PRE – SCREENING QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and our staff safe and healthy.

Have you traveled outside the United States in the past 10 days? Yes No

If yes, where? _____

Have you traveled to a US City/State with reported cases of COVID 19 in the past 10 days? Yes No

If yes, where? _____

Have you been in personal contact with a person infected with COVID-19 or who has traveled to an area with widespread and ongoing transmission of COVID-19?

Yes No

IN THE LAST 48 HOURS

Have you had a fever (99.5°F +) Yes No

Have you experienced any of the following symptoms?

Fatigue	Yes	No
New onset Headache	Yes	No
Coughing	Yes	No
Congestion	Yes	No
Loss of smell or taste	Yes	No
Sore Throat	Yes	No
Difficulty Breathing	Yes	No
Muscle Aches	Yes	No
Nausea or vomiting	Yes	No
Diarrhea	Yes	No

Patient Name: _____

Signature: _____ Date: _____

** PLEASE RETURN TO THE FRONT DESK WHEN COMPLETED**