PATIENT PRE-SCREENING QUESTIONNAIRE

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

1. Have you traveled in the past 30 days? YES or NO

2. Have you been in close contact with confirmed Covid-19 case? YES or NO

IN THE LAST 48 HOURS:

- Have you had a fever (99.5°+)? YES or NO
- Resent/new onset cough (not related to allergy or COPD) YES or NO
- Recent/new onset Sore Throat (not related to allergy) YES or NO
- Recent/new onset shortness of breath (not related to chronic disease) YES or NO
- Muscle Aches? YES or NO
- Stomach Pain? YES or NO

Print Name: _____

Signature: _____ Date: _____

****Please return this form to the front desk when completed****

Staff Initials: _____