COVID-19 Screening Questions

Please advise if in the last fourteen (14) days you have experienced any of the following:

1. Dry Cough?
2. Shortness of breath or difficulty breathing?
3. Fever or feeling feverish?
4. New loss of sense of taste or smell?
5. Close contact with a COVID-19 positive individual?
6. Chills with or without repeated shaking?
7. Fatigue/muscle pain?
8. Headache?
9. Gastrointestinal Upset?
10. Sore throat or rash?
11. Congested or runny nose?
12. Traveled in the past 14 days?

Patient Signature

Date