COVID-19 Screening

Patient Name: _____ Date: _____

Please answer yes or no to the following questions to the best of your knowledge:

Yes No

☐ ☐ Have you tested positive for COVID-19?

If yes, when? _____

☐ ☐ Have you been in close contact with anyone who has tested positive for COVID-19?

If yes, when? _____

☐ ☐ Have you had any fever, cough or flu-like symptoms?

If yes, when did it start? _____

Please list any additional pertinent information below: