COVID-19 Patient Health Screening

Patient Name ________________________________ Date__________ Appt Time__________

In the past 24 hours have you experienced any of the following:

Subjective fever (felt feverish)	☐YES	☐ NO
New or worsening cough	☐YES	☐ NO
Shortness of breath	☐YES	☐ NO
Sore throat	☐YES	☐ NO
Diarrhea	☐YES	☐ NO
Loss of smell/change of taste	☐YES	☐ NO

Current Temperature _____ F

If you answer "yes" to any of the symptoms listed above, or your temperature is 100.4 F or higher, please do not go into work. Self-isolate at home and contact your primary care physician's office for direction.

- You should isolate at home for a minimum of 7 days since symptoms first appear.
- You must also have 3 days without fevers and improvement in respiratory symptoms

IN THE PAST 14 DAYS HAVE YOU

Had close contact with an individual diagnosed with COVID-19? ☐YES ☐NO

Traveled via airplane internationally or domestically? ☐YES ☐NO

If you answer **"yes"** to either of these questions, please do not go into work. Self-quarantine at home for 14 days.

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