# COVID-19 SCREENING FORM

As a means of protecting our patients and staff-we are screening all our patients prior to admission to the clinic. Please complete, sign and date the following screening questionnaire prior to your appointment.

**Thank you so much for your cooperation!**

## PLEASE ANSWER ALL QUESTIONS:

1. Have you or a member of your household traveled by air in the last 14 days?
   Yes _____

   No _____

2. Do you have any of the following symptoms: fever/feverish, sore throat, new or existing cough, new onset shortness of breath?
   Yes_____

   No_____

3. Have you had close contact with a confirmed or probable COVID-19 case?
   Yes_____

   No ____

4. Have you had close contact with a person with acute respiratory Illness in the last 14 days?
   Yes____

   No____

5. Have you worked in a facility with confirmed COVID-19 Cases?
   Yes___

   No___

**Signature: _____ Date:_____**