PATIENT PRE-SCREENING QUESTIONNAIRE

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

Patient Name: _____

Today's Temperature (forehead/wrist- circle one) _____ Date: _____

Have you traveled to a US city/State where reported cases of COVID-19 are on the rise in the past 30 days? If yes, where? _____	YES	NO
Have you had a known exposure to any individual suspected or confirmed to have COVID-19?	YES	NO
Have you traveled to, or been in contact with anyone that has traveled to a location after which self-quarantine is recommended?	YES	NO

Within the last 48 hours have you experienced any:

Have you had a fever (99.5+ F)	YES	NO
Cough	YES	NO
Shortness of breath or difficulty breathing	YES	NO
Fatigue	YES	NO
Muscle or body aches	YES	NO
Headaches	YES	NO
New loss of taste or smell	YES	NO
Sore throat	YES	NO
Congestion or runny nose	YES	NO
Nausea or vomiting	YES	NO
Diarrhea	YES	NO