COVID-19 Screening Form ...

Patient’s name:  
Date:  
Date:  

PREADPOINTMENT CHECK

1. Have you previously been diagnosed with COVID-19, or do you think you’ve had/have COVID-19?
   - YES ☐ NO ☐
   
   (If NO to question 1, skip to question 5)

2. If YES, when and how were you confirmed positive?
   - I think I had it.
   - I had a positive nasal swab test.
   - I had a positive blood test.
   - I had a positive saliva test.
   - I currently have symptoms and am waiting for a test.

3. If you have had COVID-19, how were you confirmed negative?
   - I was diagnosed negative by a nasal swab test. How many times? How far apart?  
   - I show antibodies to COVID-19 with a blood test.
   - My doctor said I no longer have it because I don’t have any symptoms.
   - I don’t have any symptoms, so I don’t have it.

4. If you have had COVID-19, when were you confirmed negative?
   - 24 hours ago ☐ today ☐ 10 days after testing ☐

5. Do you currently have (or have you experienced) any of the following symptoms in the past 21 days:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES ☐ NO ☐</th>
<th>YES ☐ NO ☐</th>
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</thead>
<tbody>
<tr>
<td>Fever</td>
<td></td>
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<tr>
<td>Fatigue (feeling tired)</td>
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<tr>
<td>Altered or loss of taste/smell</td>
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<tr>
<td>Dry cough</td>
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<tr>
<td>Trouble breathing</td>
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<tr>
<td>Shortness of breath, difficulty breathing</td>
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<tr>
<td>Confusion</td>
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<td>Blueish lips or face</td>
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<td>Chills/repeated shaking with chills</td>
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<tr>
<td>Muscle pain</td>
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<tr>
<td>Headache or sore throat</td>
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<tr>
<td>Any other flu-like symptoms</td>
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<tr>
<td>GI upset or diarrhea</td>
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</tbody>
</table>

If fever, how did you measure it?

PLEASE LIST (if applicable)
6. Are you in contact with anyone who has been sick and/or confirmed to be COVID-19–positive?  
   YES □ NO □       YES □ NO □

7. In the past 14 days have you traveled to any regions affected by COVID-19?  
   YES □ NO □       YES □ NO □

Some medical conditions have been associated with more severe COVID-19 disease. The following questions are an attempt to determine your risk:

8. Are you over age 65?  
   YES □ NO □       YES □ NO □

9. Do you have high blood pressure?  
   YES □ NO □       YES □ NO □

   If you have high blood pressure, is it controlled?  
   YES □ NO □       YES □ NO □

10. Do you have diabetes?  
    YES □ NO □       YES □ NO □

11. Are you overweight?  
    YES □ NO □ NO ANSWER □       YES □ NO □ NO ANSWER □

12. Do you have respiratory problems?  
    YES □ NO □       YES □ NO □

13. Do you have any autoimmune disorders?  
    YES □ NO □       YES □ NO □

14. Are there any other conditions you would like to report?