Patient Pre-Screening Form

Appt date:

Temp:

Patient Name:		
	Pre-Appointment Date:	In-Office Date:
Do you/they have fever or have you/they felt hot or feverish in the last 14-21 days?	**YES NO**	**YES NO**
Are you/they having shortness of breath or other difficulties breathing?	**YES NO**	**YES NO**
Do you/they have a cough?	**YES NO**	**YES NO**
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	**YES NO**	**YES NO**
Have you/they experience recent loss of taste or smell?	**YES NO**	**YES NO**
Have you been in contact with anyone confirmed COVID-19 positive?	**YES NO** **When tested** ____________ **Result** ____________	**YES NO** **When tested** ____________ **Result** ____________
Are you currently awaiting the results of a COVID-19 test?	**YES NO**	**YES NO**
Is your age over 60?	**YES NO**	**YES NO**
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	**YES NO**	**YES NO**
Have you traveled in the past 14 days to any region affected by COVID-19?	**YES NO** **Where** ____________	**YES NO** **Where** ____________