Name: Date: Date of Birth:

COVID-19 Screening Questionnaire

Please fill out the following screening questionnaire prior to your in-office visit. This must be filled out and sent back at least 2 business days prior to your scheduled appointment date. In order to protect you and others, we are asking the following questions about symptoms and exposure to COVID-19.

❖ Have you had or do you currently have the following symptoms (check all that apply)?

- ☐ Loss of sense of smell and/or taste?
  - ☐ If so, when did it start?
  - ☐ Has it improved?
- ☐ Fevers, sweats, chills?
  - ☐ If fevers, please write range of fevers: _____
- ☐ Diarrhea?
- ☐ Nausea?
- ☐ Cough?
  - ☐ Dry?
  - ☐ Productive?
- ☐ Shortness of breath?
- ☐ Do you have a pulse oximeter? If so, what are your readings? _____
- ☐ Sore throat?
- ☐ Nasal congestion?
- ☐ Sneezing?
- ☐ Runny nose?
- ☐ Body aches?
- ☐ Fatigue/malaise?
  - ☐ Mild, moderate, or severe?

❖ Do you have any other symptoms (check all that apply)?

- ☐ Joint pain or muscle pain?
  - ☐ Is it migratory?
- ☐ Headaches?
- ☐ Nerve pain?
  - ☐ Tingling? Numbness? Burning? Stabbing?
- ☐ Memory or concentration problems?

❖ In the past 2 weeks, have you or anyone in your household traveled domestically or internationally?

- ☐ No
- ☐ Yes. If yes, where have you traveled? _____
  How long were you at your destination? _____
  Were you in contact with anyone with COVID-19 or exhibiting COVID-19 symptoms while you were away? _____

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- **In the past 2 weeks, have you or someone in your household been diagnosed, tested or quarantined under a doctor's orders for COVID-19?**
  - ☐ NO
  - ☐ Yes. If yes, please explain:

    _____
    _____
    _____
    _____
    - ☐ A doctor ordered me or someone in my household to quarantine for possible COVID-19.
    - ☐ My family member (_____spouse, child, etc.) was tested and we are waiting for results.
    - ☐ My family member (_____) tested positive.
    - ☐ My family member (_____) tested negative.
    - ☐ Someone at home has a fever, cough or difficulty breathing but has not been diagnosed.

- **In the past 2 weeks, have you or anyone in your household been in close contact with someone who has been diagnosed, tested or quarantined under a doctor's order for COVID-19?**
  - ☐ No
  - ☐ Yes. Please explain:

    _____
    _____
    _____
    _____
    _____

- **VISITOR POLICY: We strongly recommend that only the patient be allowed in the room during their appointment. We are happy to have spouses, significant others or family members listen in on speaker phone or via facetime. If the patient is a minor, one parent is permitted to be with the patient providing they have filled out the questionnaire and are not having any COVID-19 symptoms or have not been around anyone with COVID-19 or symptoms for the past 2 weeks.**

Patient signature:_____Date:_____