COVID-19 SCREENING HANDOUT

OUR PATIENT'S SAFETY IS OUR PRIMARY GOAL.

PLEASE ANSWER THE QUESTIONS BELOW TO DETERMINE IF YOU PRESENT A COVID-19 RISK.

- Have you traveled in the past 14 days: **YES** **NO**
  Where? _____
- Have you had contact with a person who has traveled within the last 14 days? **YES** **NO**
- Have you had contact with a person who has been diagnosed with the Coronavirus? **YES** **NO**
- Have you tested positive for COVID-19? **YES** **NO**
  If so, when? _____

Have you had any of the following symptoms in the past 14 days?
(CHECK BOXES THAT APPLY)

- Fever
- Chills/Repeated Shaking with Chills
- Muscle Pain
- Recent Onset Cough
- Shortness of Breath
- Other Acute Respiratory Symptoms
- Sore Throat
- New Loss of Taste or Smell
- Diarrhea