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Screening Questionnaire – COVID-19 (Coronavirus)

Questions asked at initial screening:

Name:_____ Date:_____

Please circle the appropriate responses.

1. Do you currently have symptoms of a respiratory infection?

a. NO

b. YES. – (If so, please indicate your symptoms)

Fever Shortness of breath Cough Sore throat Loss of Smell Loss of Appetite

2. Have you traveled outside this area (surrounding counties) within the past 10 days?

a. NO

b. YES – (If YES, When? and Where?)

_____

_____

3. Have you been exposed to someone who has tested positive or diagnosed with COVID-19?

a. NO

b. YES – (If YES, When? and Where?)

_____

Provider Recommendations (circle one):

Work **Do Not Work**

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