COVID-19 Health Screening Form

Patient Name:_____ Date:_____

Have you had any of the following in the past 14 days?

YES	NO	
☐	☐	Flu-like or cold-like symptoms not associated with allergies, including runny nose, body aches, and/or sneezing
☐	☐	Fever
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Headache
☐	☐	Sore throat
☐	☐	Chills or repeated shaking with chills
☐	☐	Muscle pain
☐	☐	Loss of taste or smell
☐	☐	Close contact with anyone diagnosed with COVID-19
☐	☐	Does your work involve being in groups of 2 or more, unprotected?
☐	☐	Have you been practicing safe social distancing?
☐	☐	Have you contacted your doctor's office for any reason? If yes, what for?

_____

When was the last time you were in a gathering of 2 or more people (not including your own household)?

Date:_____

I attest that the above answers are true and correct to the best of my knowledge.

_____ Date_____

Signature (Self or Guardian)

_____

Print Name of Patient