2020 Novel Coronavirus (COVID-19) Screening Questionnaire

Patient Name: __________________________________________ DOB: ________________
Driver’s Name:____________________________________________________________

Please circle YES or NO to the following questions:

1.) Have you been tested for COVID-19 and are waiting for results?

   YES  NO

2.) Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 diagnosis in the past 14 days?

   YES  NO

3.) Do you have a fever (greater than 100.4 F or 38.0 C) OR symptoms of lower respiratory illness such as cough, shortness of breath, difficulty breathing, or sore throat, runny nose, loss of taste or smell?

   YES  NO

Signature of person completing this questionnaire: _________________________________
Relationship to patient/minor (if applicable): ______________________ Date: __________
Signature of staff filling out form______________________________________________