# SCREENING FOR ALL COVID-19 PATIENTS

1. Have you been experiencing any of the following symptoms:

   A. Fever
   B. Cough
   C. Difficulty breathing/sob
   D. Sore throat
   E. Diarrhea/gi upset
   F. Loss of smell/loss of taste
   G. Body aches/fatigue
   H. Chills/shaking with chills
   I. Muscle pain
   J. Headache

2. In the last 30 days have you traveled anywhere?
   ______________________________________________________

3. In the last 14 days before symptom onset, have you had close contact with a person who tested positive for COVID-19?

4. Have you had a physical contact with a nursing home patient?

5. Have you been in the hospital recently? If so, must wear a surgical mask. All patients must wear a mask can be cloth if not recently hospitalized.

   Any positive symptoms will need to be discussed if patient can come into office, may need a room or in the negative pressure room.

NAME:______________________________________________

SIGNATURE:__________________________________________

DATE:_______________________________________________