PATIENT SCREENING

Name: _____ Chart #: _____

Appointment day/date/time:_____

Circle one: Phone appt. reminder / Pre-appt. outside / In office

Completed by (signature):_____ Date completed: _____

Please circle Yes or No below.			WHEN?	HOW LONG?	WHERE?	COMMENTS
YES	NO	Have you been near someone diagnosed with or suspected of COVID-19?				
YES	NO	Do you have anyone sick in the house?				
YES	NO	Are you taking care of anyone with COVID-19?				
YES	NO	Travelled anywhere with high COVID-19 cases, internationally or domestically, especially to big cities like New York or New Orleans?				
YES	NO	Self-isolation (stay-at-home)				
YES	NO	Have you been in any groups of more than three people you don't live with? Have you participated in large gatherings like holiday celebrations (like Memorial Day? Father's Day? July 4th?) or protests?				
YES	NO	Quarantine (medical quarantine)				
YES	NO	Have you been tested for COVID-19? If so, when and what were the results?				
YES	NO	Do you plan to be tested for COVID-19? If so, where and when?				
YES	NO	Are you a first responder-- like a nurse or Firefighter-- who has had to treat or screen people for COVID-19?				

Have you had any of the following symptoms in the past two weeks?			WHEN?	HOW LONG?	WHERE?	COMMENTS
YES	NO	Fever				
YES	NO	Congestion or runny nose				
YES	NO	Sore throat/cough				
YES	NO	Shortness of breath or difficulty breathing (chest pain, pressure)				
YES	NO	New loss of smell or taste				
YES	NO	Skin rash or redness				
YES	NO	Fatigue				
YES	NO	Muscle or body aches				
YES	NO	Nausea				
YES	NO	Diarrhea				
YES	NO	Headache				
YES	NO	Dizziness or confusion				
YES	NO	Inability to wake or stay awake				

*Appointment must be no sooner than 14 days after any of the above. 6/2020