COVID-19 Patient Screening Questionnaire

Name_____ Date_____

Screening Questions

1. Do you have a fever or have you felt feverish recently?
   Yes No
2. Do you a cough?
   Yes No
3. Are you having shortness of breath or any difficulty breathing?
   Yes No
4. Do you have chills or repeated shaking with chills?
   Yes No
5. Do you have any muscle pain?
   Yes No
6. Do you have any recent onset of headaches or sore throat?
   Yes No
7. Do you have any other flu like symptoms?
   Yes No
8. Do you have any recent lost of taste or smell?
   Yes No
9. Have you experienced any recent GI upset or diarrhea?
   Yes No
10. Are you in contact with anyone who has been confirmed to be COVID-19 positive?
    Yes No
11. Have you traveled in the past 14 days to any region affected by COVID-19?
    Yes No
12. Have you been tested for COVID-19? If Yes, What was the result?
    Yes no
13. Have you been diagnosed with COVID-19?
    Yes No
    If yes, When?_____

14. Are you over the age of 65?