Patient Screening Form

Patient Name: ______________________ **Informant: ______________________**

	Pre-Appointment	In-office
Have you, your child or any other recent acquaintances tested positive for, been diagnosed as having or have symptoms of COVID-19 or any other communicable disease? If yes when? Date _________________	____yes ____ no	____ no change ____yes ____ no
Do you/they have a fever (over 100.4 degrees) or recently had a fever (14-21 days)?	____yes ____ no	____yes ____ no
Are you/they having any shortness of breath, trouble breathing or a cough?	____yes ____ no	____yes ____ no
Have you/they recently travelled? If yes where? __________________ Date___________________	____yes ____ no	____yes ____ no
Have you/they had any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	____yes ____ no	____yes ____ no
Have you/they experienced a recent loss of taste or smell?	____yes ____ no	____yes ____ no
Staff initials		

I attest to the truthfulness of these answers and understand that if the answer to any of the questions is yes, I will be asked to reschedule today's visit.

________________________________ _______________

Patient/ Parent's Signature **Date**

	Temperature	**Staff Initials**
Patient Temperature		
Parent/ Guardian Temperature		