Phone:
Fax:

Comprehensive Internal Medicine
Covid-19 Previsit Screening Questionnaire

Patient Name:

Date of Birth

	Yes	No
1) Have you or a member of your household had any of the following symptoms in the last 14 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit?	❒	❒
2) Have you or a member of your household been tested for COVID-19 n the last 4 weeks?	❒	❒
3) Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers in the last 14 days?	❒	❒
4) Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers?	❒	❒
5) Do you have any reason to believe you or a member of your household has been exposed to or worked in close proximity with anyone who has acquired COVID-19?	❒	❒

Verbal Responses recorded by employee

Employee initials and date