COVID-19 Patient Screening Form

Patient Name

	On-Line	In-Office
Are you over 60 years of age?	YES/NO	YES/NO
Do you have a preexisting condition such as lung disease, heart disease, diabetes, kidney disease or an autoimmune disorder?	YES/NO	YES/NO
Are you experiencing shortness of breath or trouble breathing?	YES/NO	YES/NO
Do you have a temperature of 100.0° F or higher?	YES/NO	YES/NO
Are you experiencing a sore throat?	YES/NO	YES/NO
Are you coughing? YES/NO YES/NO		
Are you experiencing repeated shaking with chills?	YES/NO	YES/NO
Do you have muscle aches?	YES/NO	YES/NO
Are you experiencing gastrointestinal changes?	YES/NO	YES/NO
Have you noticed a loss of smell or taste?	YES/NO	YES/NO
Have you had contact with a known or suspected COVID-19-positive person?	YES/NO	YES/NO
In the last 12 days, have you traveled to another State or country?	YES/NO	YES/NO

*If yes to the question above, please specify:*_____