Patients Presenting to Office / Facility: COVID-19 Screening

All individuals (staff, other health care workers, family, visitors, government officials, etc.

1. Do you have any of the following symptoms (Check each symptom applicable)?

_____ Yes	_____ No	Fever, chills or repeated shaking with chills
_____ Yes	_____ No	Congestion or runny nose
_____ Yes	_____ No	Sore throat
_____ Yes	_____ No	Cough
_____ Yes	_____ No	New shortness of breath or difficult breathing
_____ Yes	_____ No	Recent sensory loss of taste and/or smell
_____ Yes	_____ No	Unusual or unexplained muscle pain
_____ Yes	_____ No	Unusual or unexplained headache
_____ Yes	_____ No	Gastro symptoms (including: abdominal pain/cramping, nausea, diarrhea and vomiting).

2. Have you or any member of your household been exposed or potentially exposed to anyone who has tested positive to COVID-19 within the last 2 weeks? _____ Yes _____ No

I am aware that providing false answers or information regarding exposure and/or possible exposure, mandatory quarantine and/or self-quarantine is a criminal offense and reportable to law enforcement and/or governmental agencies monitoring the COVID-19 pandemic.

Patient's Signature	**Patient's Name (Print)**	**Date**
Date of Birth:	**Temperature recorded by staff**	**Screener Initials**

IF "YES" TO ANY OF THE ABOVE QUESTIONS

PROVIDER APPROVAL TO BE SEEN _____ (MA OR PROVIDER INITIALS)