COVID-19 Patient Screening

Please answer **YES** or **NO** to the following:

Do you have a fever or have you felt hot or feverish recently (14-21 days)? **Yes** **No**

Are you having shortness of breath or other difficulties breathing? **Yes** **No**

Do you have a cough? **Yes** **No**

Do you have any flu-like symptoms, such as gastrointestinal upset, headache or fatigue? **Yes** **No**

Have you experienced recent loss of taste or smell? **Yes** **No**

Have you had any contact with any confirmed COVID-19 positive patients? **Yes** **No**

Is your age over 60? **Yes** **No**

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? **Yes** **No**

Have you traveled in the past 14 days to any regions affected by COVID-19? **Yes** **No**

Patient Signature: _____ Date Signed:_____