COVID-19 SCREENING QUESTIONNAIRE

The safety of our patients is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are asking everyone to complete and submit this questionnaire prior to entering the clinic. Please do not enter the clinic until your responses have been reviewed and your entry has been approved.

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our other patients.

Name:
Phone Number (mobile/home):

	Representations
1	Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Please take your temperature before you answer this question.)*** Yes ☐ No ☐ Fever (100.4° F/37.8° C or greater as measured by an oral thermometer) Yes ☐ No ☐ Cough Yes ☐ No ☐ Shortness of breath or difficulty breathing Yes ☐ No ☐ Sore throat Yes ☐ No ☐ New loss of taste or smell Yes ☐ No ☐ Chills Yes ☐ No ☐ Head or muscle aches Yes ☐ No ☐ Nausea, diarrhea, vomiting
2	In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? Yes ☐ No☐
3	In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes ☐ No☐
4	Have you been tested for COVID-19 and are waiting to receive test results? Yes ☐ No☐

5	Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? Yes ☐ No☐ *NOTE: If you have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact your manager or human resources representative when: (1) you have had no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) your other symptoms have improved;* ***and*** *at least 7 days have elapsed since your symptoms first appeared.*
6	In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐
7	In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐
8	Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation. Yes ☐ No☐ Explanation:_____.

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature:_____ Date: _____

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential.

Access to clinic (circle one): Approved Denied

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