Patient Screening Form

Please fill this out prior to your appointment and bring it with you. If you answered yes, let's chat. A telemedicine appointment may be better for you right now.

Patient Name: Age:

	Before Appointment	During Appt.
	Date:	Date:
Do you have a fever or have you felt hot or feverish recently. Have you been symptom-free for at least 14 days without the use of cough or fever suppressing medications?	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
Do you have *new* shortness of breath or other breathing difficulties?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have a cough? What type (dry, productive, other _____)	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other flu-like symptoms such as sore throat, chills, upset stomach, headache or fatigue, other _____?	☐ Yes ☐ No	☐ Yes ☐ No
Have you experienced a recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Have you been in contact with anyone confirmed with COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
Have you traveled to any regions affected by COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other health concerns we should be aware of? Heart disease, diabetes, lung disease, kidney disease or any auto-immune disorders? _____		