COVID 19 SCREENING: PATIENT

PLEASE FILL OUT *LESS THAN 24 HOURS* BEFORE YOUR SCHEDULED OFFICE VISIT
ONE PER VISITOR (PATIENT & PARENT)

Patient MRN:
DATE OF OFFICE VISIT:

Screening questions for anyone entering the office
If any response to the below questions for anyone entering the office is yes, please speak with our office.

1. Have you been diagnosed with COVID-19 in the past 30 days? Yes or No

2. Do you live with someone who has been diagnosed with COVID-19 in the past 30 days? Yes or No

3. Have you had any of these symptoms that are new, or not explained by a pre-existing condition? Yes or No

			PAST 24 HRS	Past 14 days	Not in the past 14 days
a. Fever/chills (37.8°C/100.4°F or higher)	No	if Yes			
b. Sore throat	No	if Yes			
c. Difficulty breathing	No	if Yes			
d. Unexplained muscle aches	No	if Yes			
e. Cough	No	if Yes			
f. Loss of senses of smell or taste	No	if Yes			
g. Nasal congestion	No	if Yes			
h. Diarrhea (3 or more loose stools in 24 hours)	No	if Yes			
i. Eye redness +/- discharge (pink eye, not allergy)	No	if Yes			

4. Do you have a runny nose or sneezing that is new or not explained by pre-existing conditions? Yes or No

5. In the past 14 days have you returned from travel outside the Bay Area including overseas? Yes or No

If yes, where did you travel? ____

6. In the past 14 days have you been in unprotected contact with someone diagnosed with COVID-19?
(Unprotected means without full personal protective equipment at work, or close contact in the community)

Yes or No