COVID-19 PANDEMIC QUESTIONNAIRE/SCREENING

Please answer the following:

	YES	NO
Do you have any health conditions that we should be aware of? If yes, please list:		
Do you have a fever or above normal temperature?		
Are you experiencing shortness of breath or having trouble breathing?		
Do you have a dry cough, runny nose or sore throat?		
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?		
Have you been tested for COVID-19 or waiting on the results?		
Have you been in contact with anyone who has tested positive for COVID-19?		
Have you traveled in the last 14 days? If yes, where have you traveled?		

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

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Patient Name and DOB Printed

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Patient Signature

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Date