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COVID-19 SCREENING QUESTIONAIRE

1. Have you recently traveled to an area with known local spread of COVID-19:

☐ Yes ☐ No

2. Have you been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least 5 minutes, or had direct contact with their mucus or saliva, in the past 14 days?

☐ Yes ☐ No

3. In the last 48 hours, have you had any of the following NEW symptoms?

☐ Fever of 100.5 F (38 C) or above, or possible fever symptoms like alternating chills and sweating
☐ Cough
☐ Trouble breathing, shortness of breath or severe wheezing
☐ Chills or repeated shaking with chills
☐ Muscle aches
☐ Sore throat
☐ Loss of smell or taste, or a change in taste
☐ Nausea, vomiting or diarrhea
☐ Headache
☐ None of the above

IF YOU HAVE MARKED "YES" OR HAVE ANY OF THE ABOVE SYMPTOMS, PLEASE POSTPONE YOUR VISIT FOR AT LEAST 14 DAYS FROM THE DAY YOUR SYMPTOMS BEGAN. TELEHEALTH SERVICES ARE AVAILABLE.

4. Do you have any of the following diagnosis or conditions:

☐ Diabetes
☐ Hypertension
☐ Recent surgery
☐ Chemotherapy/Immunocompromise
☐ Severe Obesity
☐ Heart or Liver Disease
☐ Asthma (Moderate to Severe)
☐ Chronic Lung or Kidney Disease

If you have any of the above conditions stay with Telehealth services for now.

5. Will you wear a face mask at all times in the building & the waiting room?

6. Can you comply with 6 feet of separation & no touch rule with everyone in office?

7. Will you consent to having your temperature taken with a touch less thermometer?

8. Do you have any of the following possible emergency symptoms?

☐ Struggling to breathe or fighting for breath even while inactive or when resting
☐ Feeling about to collapse every time you stand or sit up

IF YOU HAVE ANY OF THE ABOVE EMERGENCY SYMPTOMS CONTACT YOUR PHYSCIAN OR DIAL 911.