Coronavirus (COVID-19) Screening Questionnaire

Patient Name:____ Date:___________________

DOB: ___________________ Age:_________

1. Have you traveled anywhere in the last 3 weeks (especially outside the USA)? ☐ No ☐ Yes If yes where?

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2. Have you been in contact with anybody that was sick in the last 3 weeks? ☐ No ☐ Yes If so please give specifics. (This could be a friend, family or co-worker.)

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3. Have you been to a region of high contagion? ☐ No ☐ Yes If yes where?

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4. Do you have any symptoms of a cold or flu? ☐ No ☐ Yes
5. Do you have a cough? ☐ No ☐ Yes
6. Do you have any difficulty breathing? ☐ No ☐ Yes
7. Do you have a runny nose? ☐ No ☐ Yes
8. Do you have a sore throat? ☐ No ☐ Yes
9. Do you have any illness related body aches? ☐ No ☐ Yes
10. Have you Previously Tested for COVID-19? ☐ No ☐ Yes
    a. Positive for IgM ☐ No ☐ Yes
    b. Positive for IgG ☐ No ☐ Yes

I attest that I have fully and accurately answered the above questions. I acknowledge that I will be asked the same screening questions listed above, verbally, for EVERY future appointment and agree to answer all screening questions truthfully and honestly going forward. I also acknowledge it is my responsibility to inform ALHC staff of any symptoms I may have or came into contact with before arriving at the office.

Patient's / Guardian's Signature ____________________________________ **Date:**_________________