1. Have you tested positive for COVID-19 in the past 10 days? Check one.

[ ]  Yes [ ]  No

1. Have you experienced any of the following symptoms in the past 48 hours? Check all that apply.
[ ]  Fever or chills [ ]  New loss of taste or smell
[ ]  Cough [ ]  Sore throat
[ ]  Shortness of breath or difficulty breathing [ ]  Congestion or runny nose
[ ]  Fatigue [ ]  Nausea or vomiting
[ ]  Muscle or body aches [ ]  Diarrhea
[ ]  Headache [ ]  NO SYMPTOMS
2. Within the past 14 days, have you been in close physical contact (6 feet or closer for 15 continuous minutes) with anyone who is known to have laboratory-confirmed COVID-19?

[ ]  Yes [ ]  No
3. Are you isolating or quarantining because you may have been exposed to a person with COVID-19, or you are worried that you may be sick with COVID-19?

[ ]  Yes [ ]  No
4. Are you currently waiting on the result of a COVID-19 test?

[ ]  Yes [ ]  No

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name: |  |
| Date of Birth: |  |
| Cell Phone: |  |
| Are you a PATIENT OR A VISITOR? |

|  |
| --- |
| *For Office Use Only* |
| Patients  | If patient answers “yes” to any of the above, please notify Nurse Manager to determine plan of care. |
| Visitors | If visitor answers “yes” to any of the above, please notify Nurse Manager. |
|  |
| Staff Signature: |  | Date: |  |