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: |  |