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

   ☐ Yes ☐ No

2. Have you experienced any of the following symptoms in the past 48 hours? Check all that apply.

   ☐ Fever or chills
   ☐ Cough
   ☐ Shortness of breath or difficulty breathing
   ☐ Fatigue
   ☐ Muscle or body aches
   ☐ Headache
   ☐ New loss of taste or smell
   ☐ Sore throat
   ☐ Congestion or runny nose
   ☐ Nausea or vomiting
   ☐ Diarrhea
   ☐ NO SYMPTOMS

3. 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

4. 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

5. 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: