**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COVID-19 SCREENING QUESTIONNAIRE**

 **Status of condition?**

1. Worsened
2. Improving
3. No change

**Frequency of symptoms?**

1. Continuously
2. Intermittently

**Do you have any of the following:**

1. **Have you had a fever in the last week?**
	1. Yes
	2. No
2. **Do you have a cough?**
	1. Yes
	2. No
3. **Are you experiencing shortness of breath?**
	1. Yes
	2. No
4. **Are you experiencing a loss of taste?**
	1. Yes
	2. No
5. **Are you experiencing abdominal pain, vomiting, or diarrhea? (Please Circle)**
	1. Yes
	2. No
6. **Have you had close contact with or cared for someone diagnosed with COVID-19?**
	1. Yes
	2. No
7. **Have you or anyone in your household been diagnosed with COVID-19?**
	1. Yes
	2. No
8. **Please list any other symptoms that you are experiencing below.**