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COVID – 19 SCREENING FORM:

1) **Do you have any symptoms of COVID – 19?**
   - **i.** These could include a fever, cough, sore throat, fatigue, loss of taste/smell, GI symptoms, or any other known COVID – 19 symptoms.
   - **ii.** **Yes** ☐ **No** ☐
   - **iii.** If yes, write your symptoms below and when the symptoms started:

     _____

2) **Have you done a quarantine due to known or potential exposure to COVID – 19 <u>OR</u> have you been asked to do a quarantine due to known or potential exposure to COVID – 19?**
   - **i.** **Yes** ☐ **No** ☐
   - **ii.** If yes, write the dates when the quarantine started and stopped:

     Start date: _____ End date:_____

3) **Have you been tested for COVID – 19 within the last 2 weeks?**
   - **i.** **Yes** ☐ **No** ☐
   - **ii.** If yes, please provide the reason for testing, date of test, and the results:

     Reason:_____ Date:_____ Result:_____

4) **Have you been vaccinated against COVID – 19?**
   - **i.** **Yes** ☐ **No** ☐
   - **ii.** If you have been vaccinated, list the dates of your vaccination(s):

     1st dose:_____ 2nd dose:_____

     3rd dose:_____ 4th dose:_____

***** We do ask that you provide your CDC vaccination card to the receptionist, this is used by many of the facilities we work with. We appreciate your cooperation with this.**

Patient name:_____ Patient date of birth:_____

_____ _____

Patient Signature **Today's Date**

By typing your name on the signature line, you agree with the terms and conditions of the document.