COVID-19 SCREENING FORM

Patient Name: _____

DOB: _____

Today's Date: _____

Please Circle YES or NO to the following questions:

1. Have you traveled outside of the United States in the last 14 days

   YES NO

2. Have you traveled within the United States in the last 14 days?

   YES NO

3. Have you been on a cruise ship in the last 14 days

   YES NO

4. Have you been in close contact with anyone who has traveled domestically or internationally in the last 14 day?

   YES NO

5. Have you attended any events or gatherings with more than 10 people?

   YES NO

6. Have you been in close contact with a person known to have the Novel Coronavirus?

   YES NO

7. Have you been asked to self-quarantine?

   YES NO

8. Do you currently have a fever or lower respiratory symptoms such as a cough or shortness of breath?

   YES NO

9. Do you have a new onset of cold symptoms such as a cough and runny nose?

   YES NO

_____ _____

Patient Signature Date

Please complete and sign this form and email it to our office before your scheduled appointment:
caroline@drkoplin.com